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THE MEDICAL JOURNAL OF AUSTRALIA

VOL. I.—30TH YEAR. SYDNEY, SATURDAY, JANUARY 16, 1943. No. 3.

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An Address.[1]

By ALAN E. LEE,

President of the Queensland Branch of the British Medical Association.

SINCE the delivery of a presidential address is a rare and usually a unique occurrence in one's life, concerning which any previous experience is lacking, its preparation has seemed to me more difficult than that of purely technical papers.

In an address to a voluntary organization such as a Branch of the British Medical Association, the subjects to be covered would seem to be threefold: (*a*) by indicating the advantages of membership in the society, to attract non-members and to encourage waverers within its ranks; (*b*) to survey the activities of the past year; and (*c*) to forecast the shape of future events.

The President of the Branch must thus assume the triple role of propagandist, historian and prophet.

As our Association is the only organization that can claim to represent the medical profession in Australia, the chief guardian of professional standards, and an agency constantly working for the maintenance and improvement of conditions affecting every doctor, it might repay us to discuss briefly why our membership remains on a voluntary basis.

In the Memorandum of Association of all Australian Branches there is a clause transplanted from the Parent Association which reads as follows:

> Provided that the Association shall not support with its funds any object or endeavour to impose on or procure to be observed by its members or others any regulation, restriction or condition which if an object of the Association would make it a Trade Union.

What reason actuated the Parent Association in so forbidding actions which would make it a trades union is unknown to me. I have heard it described as an example of English snobbishness. And yet our Association has all the duties and responsibilities of a professional union; and there is much to be said in favour of its registration as a trades union, in the same way as the industrial unions are registered.

By bringing our organization into closer association with these bodies, it might well create a great accession of political power to our numerically weak body. At the same time the operation of the compulsory unionism clauses would throw on us the responsibility of accepting all registered practitioners within our ranks. Obviously the Branch Councils would then have to accept many of the duties and some of the disciplinary powers now vested in the medical boards.

While such a move towards trades unionism should not be undertaken lightly, nevertheless, it is, I feel, a matter which merits very careful future consideration.

But since we are still a voluntary organization, let us consider what benefits are associated with its membership. The Council of the Branch has been concerned recently about the little value some doctors seem to attach to their membership.

Amongst its members on active service there have been several examples in which doctors have elected to resign from the Branch rather than make an effort to pay the reduced subscriptions asked from them, and sometimes even rather than accept the means of continued membership which the Council is empowered to offer members in necessitous circumstances. Yet it is these members on active service who stand to gain most from the present and future activities of the Branch.

Amongst the swirling blasts of post-war reconstruction, they would indeed stand naked and alone, were it not for the protection afforded to them, members or non-members, by the massive influence of our Association. Even looking at the matter of membership from a purely financial viewpoint, the benevolence of members will continue to extend to those requiring monetary assistance, far greater aid than the moderate sum needed for membership.

Now let us return to the benefits of membership in such a professional association. Through the willing help of the librarian of the Royal Australasian College of Surgeons, I have obtained information concerning the aims and objects of some early Australian medical societies.

[1] Read at the annual meeting of the Queensland Branch of the British Medical Association on December 11, 1942.

On July 20, 1858, in his inaugural address to the Medical Society of Geelong, the President spoke as follows:

I trust that the establishment of this Society may be the harbinger of a better understanding between us, that in the search after knowledge, and the desire of imparting information to one another, the result of each other's reading and experience, those clouds of jealousy and distrust which have too long hovered above us, and obscured our better nature, may be dispersed.

The creation of a better understanding between medical men is still a basic reason for joining a society.

Isolated from each other in our daily work, as many of us must be, the common go-betweens fickle and unreliable patients, the development within the Association of bonds of comradeship becomes a paramount necessity. In this lack non-members of the British Medical Association suffer severely, while conversely the more closely members join in the work of the Branch, in council and committees, the greater grows their mutual understanding.

The published objects of another early Australian medical society so admirably express the advantages of a professional organization, that were there time an interesting hour might be spent in discussing how far, in the intervening seventy-five years, success has been attained in their fulfilment.

Formed on April 29, 1868, the Medico-Ethical Society had these following objects:

The creation of a better understanding between members of the profession in their various relations with each other.

The obtainment from the public of a more sufficient recognition of our position and services, and by consequence a more adequate remuneration for the latter.

The determined resistance by us to the prevailing practice of public bodies, to consider medical appointments as necessarily honorary.

The establishment, as far as possible, of an equitable scale of fees, both as a guide in private practice and in the case of medical witnesses.

Resistance to the system of club-practice, as it now exists, and the substitution of some preferable mode of attending those persons whose circumstances do not enable them to pay the ordinary charges for medical attendance.

The prevention of imposition on Medical Charities.

Repression of irregular practice, by the systematic prosecution of offenders against the *Medical Act*.

The establishment of a Court-Medical to which disputes between members of the profession may be submitted for arbitration.

To define and to discountenance all unprofessional usages.

The Medico-Ethical Society is dead and gone, but its objects still survive in the activities of the British Medical Association.

Success has been attained in some; in others, for example, such as fees for medical witnesses, negotiation is being conducted by your Council at this very time.

It will be noted that in 1868, and indeed for long after, the objects of a medical society were limited to establishing good relations between doctor and doctor, and between doctor and patient.

The time was still distant when new doctrines of the duties of the State in regard to the health of the community were to face the practising profession with ominous signs of change in the control of practice and even in its very nature.

Today we are faced with the situation that the maintenance of health—of positive health as many of its protagonists insist on labelling it—is regarded as a vital function of the State.

While already education and preventive medicine have become largely State responsibilities, Governments are becoming increasingly interested in the economic condition of the people, and in the standards of curative medicine, which form together the four-sided basis on which this edifice of positive health is to be created.

Though many have deplored the gulf which is said to exist between preventive and curative medicine, Sir George Newman has stated truly that this latter practice, by postponing the event of death, is in the most real sense preventive medicine.

It is little to be wondered then that the standards of curative medicine should receive the critical scrutiny of the State; and it is for the British Medical Association members to see that their standards are maintained at so high a level that no revolutionary alternative to present practice can offer any hope of betterment. The technical and ethical standards of every individual member thus become of vital interest to our Association.

When the standard of practice of any doctor falls below the accepted level, he harms not only his patient and himself, but the cause of the whole organized profession, and *vice versa*.

It becomes then the duty of our society, by maintaining rigid ethical standards, and offering constant post-graduate instruction, to see that each doctor merits a place in the ranks of his learned profession.

Branch Activity.

During the past year the Branch and its Council have carried on many of the activities already enumerated.

In the forefront of these must be placed its educational activities. The ever-growing advances in medical knowledge, the critical scrutiny of the State, and the prime necessity to maintain the professional standards of its members—all these render it essential that the Association shall not only offer, but demand of its members, their participation in post-graduate study.

Because the whole Branch has this common interest in the graduate activities of each of its members, it has seemed wise to the Council that a record of attendances at meetings of the Branch and of its Post-Graduate Committee should be preserved; and the book which you are asked to sign this evening embodies this design. Though the more obvious purpose of this record is for the information of the Branch organization, it requires little imagination to envisage a time when the interest of State administrative officials in the standards of practising doctors may be sufficiently acute to make some of us grateful for this witness to a search after knowledge.

In spite of the constant overwork to which members have been subject, the usual programmes of Branch meetings and of post-graduate courses and lectures have continued; and it is a matter of great pleasure to record the excellent attendances that have been forthcoming.

We have been honoured by the presence of many interstate visitors, spending the winter here for reasons less concerned with their own health and comfort than our own; while of great importance has been the educational liaison effected with many medical officers of the United States Army.

Isolated as we have been by distance and circumstances from more direct contact with overseas medical centres, the opportunity of instruction by, and discussions with, these professional cousins has been a pleasant hiatus within the grim structure of the war.

The administrative work of the Council has been concerned mainly with war emergency organization, and with matters concerning the Commonwealth Government.

The development of the Federal and State Medical Coordination Committees as a liaison between civil practice and its needs and the demands of the Army has been an event of considerable importance; and the great power of control over civil practice with which they are vested, though cheerfully borne today because of the urgency of the situation, is still a valuable testing ground of the reactions of members to some of the mooted compulsory medical schemes of the future.

In the immediate future a confident call is being made upon the further benevolence of members. Since the outbreak of war, when doctors in private practice enlisted for active service, their patients must of necessity be cared for by the remaining civil practitioners.

As an expression of their desire to share this increased income with their absent colleagues, certain legal agreements were enacted, of which the Metropolitan Scheme was the most important. In accordance with the agreement this terminates at the end of this month.

A general meeting of the Branch held on November 11 has decided that future aid shall be offered on a different basis. Whereas in the past payment has been made to beneficiaries as a right, regardless of their financial need, help will now be offered only to those members on active service who can show their need. This limitation has become essential because of the greatly increased taxation to which civilian practitioners are now subject. The limitations of the old scheme, however, have been set aside; and within the expressed conditions, aid is offered to any member of the Queensland Branch on active service, or to any civilian member affected by enemy action. Parallel with this increased scope, all members of the Branch are now invited to become contributors to the scheme.

The financial committment and the tenure of the contribution are limited, and the object is so worthy that the Council will be disappointed if the scheme is not an immediate and complete success.

Concerning relations of the medical profession to the State, it is significant that the work of the Council has been almost entirely concerned with matters affecting the Federal Government. Only one or two minor matters affecting the State Government have been discussed. With regard to the Federal Government, however, apart from war organization a problem of great importance has occupied much of the Council's attention.

Though the subject of this discussion, the provision of a contract medical service for the widows and dependants of soldiers killed in this war, would seem a simple problem, and one moreover demanding the sympathetic consideration of the profession, its importance derives from the light it throws on the organization of the British Medical Association for collective negotiation with the Federal Government, and especially on the efficacy or otherwise of the Federal Council in this regard.

To understand the problem, these points must be understood. First, that though the recipients of this medical benefit are widows and dependants of deceased soldiers, the Commonwealth Government is paying for the service; and secondly, that after a similar contract had been arranged in 1923, it was found impossible in the intervening years to secure any modification of its terms to suit the changing economic conditions.

The Queensland Council therefore insisted that the Federal Council in its negotiation should secure such a contract as would prove acceptable for many years to come; and because the contract was with a Government department, that there should be no concessional aspects in its financial provisions.

Unfortunately, the Federal Council failed in both these respects. It agreed to a service of limited scope, based on the indefinite family unit instead of the straightforward unit rate (per person); while it accepted a premium of twenty-six shillings *per annum* metropolitan and thirty-two shillings *per annum* country, arrived at by averaging the lodge rates in the various States; these rates having been already shown in evidence before the National Health Insurance Commission to be concessional rates.

Since the Queensland lodge rates are the highest in Australia, this averaging created an unfortunate comparison between the payments of lodges and of the Commonwealth Government for the same services; and threatened possible repercussions with the lodges. Finally there was some reason to believe that if Queensland liked to enter into separate negotiations with the Repatriation Department it could obtain more satisfactory terms.

Faced with this situation, what was the Queensland Council to do? If it agreed to the Federal Council's terms, it exposed its members to troubles with their lodges, with whom by patient statesmanship over many years cordial relations had been created; as well as to accepting a bad bargain with the Repatriation Department. Yet if it did not do so, it must publish to the Federal Government the unfortunate fact that the Federal Council could not command the adhesion of all the Branches to its decisions.

This taunt, that the Federal Council did not represent the profession in Australia, had been made already in evidence before the National Health Insurance Commission by a very senior officer of the Federal Government.

And there were yet other aspects to the question. If an Australian-wide contract rate was to be struck by averaging the State lodge rates, then Queensland, with the highest rate, by its adherence would secure a higher average for the whole Australian profession; by its withdrawal, though it would benefit Queensland, it would correspondingly harm the rest of the States.

Here, quite apart from any failings of the Federal Council, we have a clear example of that contest of State Rights *versus* Federalism, which will impinge on many aspects of our community life in the coming years. Are we to be Queenslanders first or Australians?

A solution which should satisfy all parties has been proposed, and out of this unfortunate affair a stronger Federal Council should emerge. For there is little doubt that the Federal Council of the British Medical Association in Australia, as the negotiating body for the profession with the Federal Government, in the near future will hold in its hand our lives and destinies.

At present, by its Constitution and its practice, the Federal Council is ill-fitted to carry this load of responsibility. Though in a general way one of its objects is "to promote and maintain the interests of the Medical profession in Australia", it appears to lack the power to bind the Branches to its decisions. It needs these powers, and it seems essential that each Branch delegate to it such control, in the same way as in the political sphere the State Governments are to be asked to delegate certain powers to the Federal Government.

It is also ill-fitted to formulate a policy of its own. Prior to its meetings, the agenda has been considered by the Branch councils, whose members therefore attend with instructions how to vote. Argument in the Federal Council is therefore often powerless to sway decisions, which have already been made in the State councils.

It seems clear, that if any unification of policy is to be achieved, the office holders of the Federal Council must periodically visit the State councils, and there mould the varying State policies towards a common aim. Not only will this make for unity, but by more members of the Council than the two Branch nominees becoming familiar with the particular State problem and desires, it will ensure that such views are properly considered at the Council meetings.

Had such a course been followed at any time within the last two years, it is probable that the repatriation contract would have had much smoother sailing than it did.

So much attention has been paid to this problem of the Federal Council because in the near future it must assume the leadership of the profession in the tasks of post-war reconstruction. Signs multiply on every hand that in this building of the post-war world the reorganization of health activities is to occupy a foremost place. If when this comes, and none of us knows how soon that may be, we are not to find ourselves dwellers in a strange and alien home, it behoves us now to work on our plans and offer what help we may to the architects of reconstruction.

The present organization of medical practice is like a solid but somewhat old-fashioned home. There must be some modernization. Is it to be brought about by a little pulling down and some reconstruction of the old building, or is the whole structure to be pulled down and built afresh? Though all such up-rootings have their discomforts, there might be much to say for this latter view, if it could be built to our own plans. But just because we are not sure the architects will even consult us, many of us think we would be wiser to stick to our old home, and modernize it speedily, and with care and skill.

It is of paramount necessity that every doctor should understand the various plans that are being proposed for the future nature of medical practice. Much of this planning has been formulated by members of our Branch, and during the early part of the year, three consecutive general meetings were devoted to the discussion of schemes advocated respectively by Sir Raphael Cilento,[1] by Dr. T. A. Price and by myself.[2]

But even amongst the medical profession there can be no possible unanimity on what system will best preserve the public health. Habits of mind, the effect of environ-

ment, political views, and degrees of attachment to present circumstances—all these colour and condition one's hopes for the future. It is nevertheless true that the foundation of any medical service, private or public, must be the medical practitioner. He is its anchor, its pivot, its instrument; and a service which fails to receive his goodwill must fail.

Though the approval of the medical profession is essential for the success of any plan for the reconstruction of health services, it is very doubtful whether the organized profession should itself sponsor any new plan before the jury of the people. By so doing it enters the lists as a propagandist, and surely weakens its position as the ultimate judge of what shall be accepted or rejected.

Rather I believe the attitude of the British Medical Association should be this: we uphold a system of medical care which has gradually evolved by the best of all methods, that of trial and experiment, which debars no one from adequate care, which is efficient and is still evolving along lines about which there is fairly general agreement towards ever more effective service.

We will study any new plans with the greatest of care; but we propose to continue with the present basis of practice, irrespective of political or other arguments, until we are convinced that some other system can better preserve the health of the people.

While schemes for reconstruction should not be sponsored by the British Medical Association, it is for individuals and groups within the profession to produce the ideas and the plans which ferment evolution.

Though members may advocate any proposals they choose, it is well to remember that it is only on the technical side of medical care that such expert knowledge is usually available as will give their plans special claims to consideration.

Especially I believe they should avoid too much preoccupation with the financial side of medical care. This can never be a dominant factor in determining the nature of future practice.

With the present structure of practice no person is debarred from obtaining adequate medical attention because of a financial barrier. If health cannot be preserved on a fee-for-service basis, some method of concessional care is readily available. And even were such concessional services less readily available, there is in Australia a vast financial reserve that might better be diverted towards health preservation than as at present towards its dissipation.

When one considers that expenditure on health services for all Australia needs perhaps £15,000,000 *per annum*, while the expenditure on alcohol in 1940-1941 was £42,000,000 and tobacco £25,000,000, and that perhaps £40,000,000 per year is spent in betting, too much emphasis on the cost of health services appears farcical.

Concerning the political aspects of health services, our small numbers make us impotent. One need be less than a prophet, however, to see that the political bias of the present Federal Government is towards the adoption of a nationalized salaried service.

Because it is available to them, fortified by masses of detail, however inaccurate, the scheme of the National Health and Medical Research Council[2] will form the basis of any service they may try to introduce. It is quite unpardonable that any member should fail to study this document, together with the criticisms by Brown.[4]

Provided the profession presents a solid front, we may say of the attitude of the Federal Government to this scheme, without irreverence, that the Government proposes, but the medical profession disposes.

And with this thought I will conclude this address. There was never a time when our profession so needed to know its own mind, that it might present an unbroken front to whatever menaces its safety, and the care of the health of the people. But, granted this solidarity, with constant vigilance, keeping our powder dry, we need have no fears for our future welfare.

References.

(1) Raphael Cilento: "A Salaried State Medical Service", THE MEDICAL JOURNAL OF AUSTRALIA, March 28, 1942, page 363.
(2) Alan E. Lee: "Must there be a Revolution in Medical Practice?", THE MEDICAL JOURNAL OF AUSTRALIA, August 29, 1942, page 161.
(3) National Health and Medical Research Council: "An Outline of a Possible Scheme for a Salaried Medical Service", THE MEDICAL JOURNAL OF AUSTRALIA, December 19, 1941, page 710.
(4) Arthur E. Brown: "Suggestions Critical of and Alternative to the Outline of a Possible Salaried Medical Service, as set out in the Report of the National Health and Medical Research Council, 1942", THE MEDICAL JOURNAL OF AUSTRALIA, October 31, 1942, page 393.

Notes on Books, Current Journals and New Appliances.

SOME RECENT BOOKS ON SOVIET RUSSIA.

IN these days when Soviet Russia figures so prominently in the news, books dealing with that country are in great demand. The importation of books from England and America is at present hazardous and costly and book lovers should therefore feel grateful to Angus and Robertson, of Sydney, who are publishing quite a number of books of importance. Among these which have recently appeared are three which deal with the Soviet Republic.

Anna Louise Strong has in "Our Russian Front"[1] presented an enthusiastic picture of the country, of its people, of its government and of the way in which government and people prepared for the present war. Of special interest are chapters on the modernized Red Army, on the Soviet smashing of the fifth column and on the Soviet-German non-agression pact which is described as "the pact that blocked Hitler". Even though some readers may discount some of what Miss Strong writes because of her obvious enthusiasm, no one can read this book without both interest and profit.

One of the most important books published during this war is "Mission to Moscow"[2] by Joseph E. Davies, who was United States Ambassador to the Soviet Union from 1936 to 1938. This book is not written as a continuous tale. It consists of verbatim reproductions of confidential dispatches written by the author to the State Department, of official and personal correspondence, current diary and journal entries, including notes and comments made up to October, 1941. In these documents the reader finds a complete picture of the Soviet State. The treason trials are described and discussed and Mr. Davies shows that the result of the trials was to put an end to Nazi fifth column activities. The author's observations were so discerning that he was able to tell the President of the United States that the deeds of the Red Army would amaze the world. But it is not intended to review this truly remarkable book; rather do we wish to recommend it to readers. It is the kind of book which will be a work of reference in years to come.

A book of somewhat different kind—the tale of a competent journalist—is "Only the Stars are Neutral"[3] by Quentin Reynolds, already well known as the author of "London Diary". This book is not exclusively devoted to Russia, but a large part of it describes the author's experiences and impressions of Moscow, the trans-Ural country and so on. It is a book which holds the interest and gives hope of a bright future.

All three books mentioned here give the reader a feeling of profound admiration and respect for Soviet Russia's organization, fixity of purpose and powers of endurance. Though not really similar, they are in certain respects complementary to one another. Not to read them now will be an occasion for regret later on.

[1] "Our Russian Front", by Anna Louise Strong; 1942. Sydney: Angus and Robertson Limited. Crown 8vo, pp. 260. Price: 8s. 6d. net.

[2] "Mission to Moscow", a record of confidential dispatches to the State Department, official and personal correspondence, current diary and journal entries, including notes and comment up to October, 1941, by Joseph E. Davies; 1942. Sydney: Angus and Robertson Limited. Demy 8vo, pp. 532, with illustrations. Price: 14s. 6d. net.

[3] "Only the Stars are Neutral", by Quentin Reynolds; 1942. Sydney: Angus and Robertson, Limited. London: Cassell and Company, Limited. 8½" × 5½", pp. 288. Price: 10s. 6d.

The Medical Journal of Australia

SATURDAY, JANUARY 16, 1943.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: Initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

AUSTRALIAN MEDICAL HISTORY AND MUSEUMS.

THE Jackson Lecture published in this journal on December 5, 1942, is a document which demands the attention of every reader. That Professor John Bostock chose as his subject "The Place of History in War and Post-War Problems" was most opportune. It is the kind of subject which the historian Sandford Jackson would have approved had he been alive today; and incidentally readers may be reminded that the lecture was established by the Queensland Branch of the British Medical Association during Sandford Jackson's lifetime; he therefore knew that his historical researches would not be cast on one side and forgotten. Professor Bostock chose a large subject and discussed it with the erudition that we have learned to expect from him. Readers may not agree with all his views on war, the post-war problems and "the way out"; they will scarcely, however, disagree with his contention that as an essential preliminary for the new world of tomorrow we need "a better adult education". Professor Bostock holds that this will not be gained unless we pay more attention to history and cease to pay lip service to science and knowledge. Since Australian medicine is gravely concerned about its own future, some thought may be given to our attitude to Australian medical history and its records, a subject mentioned by Professor Bostock in the latter part of his address.

History, we are told by Professor J. T. Shotwell, of Columbia University,[1] in the wider sense is all that has happened, not merely all the phenomena of human life, but those of the natural world as well—it includes everything that undergoes change. In its narrower meaning history is the description and record of this universal process. The word "history" comes from the Greek *ἱστορία*, a word used by the Ionians in the sixth century B.C. to denote the search for knowledge in the widest sense. It meant inquiry and investigation and was not concerned with narrative. The narrator, the story-teller, came into prominence later. History is thus a science and an art. The scientist is not always an accomplished artist. Shotwell writes that the scientific historian, deeply interested in the search for truth, is generally only a poor artist, and "his uncoloured pictures of the past will never rank in literature beside the splendid distortions which glow in the pages of a Michelet or Macaulay". History the art, he states, in so far as it is conditioned upon genius, has no single traceable line of development. Here the product of the age of Pericles remains unsurpassed. On the other hand history has developed and has raised with it a group of sciences "which serve either as tools for investigation or as a basis for testing the results". The "vast gulf" that lies between the history of Egypt by Herodotus and that by Flinders Petrie is a measure of the achievement of history working in this way. A narrator of history is probably more eclectic than he intends to be; he must be critical, for he has to interpret. To do this he must have perspective and quite obviously he may be too close to his subject. It would be much more difficult to write an unbiased, a true, account of the last three years of war than it will be, say, in fifty years time. A medical historian, like any other, needs perspective and must have a critical judgement as well as the record of events in the past. This is specially true of any medical endeavour that is not related only to mere scientific fact.

Australia is a young country and its medical historians have been few. Its early medical history has been traced by some who have felt the urge and had the time to undertake the task. Most of the information has been hidden away in private journals, in the early newspapers and in other documents. We still await the historian who will cover the story of, let us say, the first hundred years of medical life in this country. Australian medicine of the future needs such a record, not only from the literary or from the human point of view, but as a source of inspiration. On previous occasions we have declared in reference to medical history that no subject in the whole range of human endeavour is so full of human interest, no subject holds such romance, no subject is more replete with stories of self-sacrifice and devotion to an ideal and no subject can give greater encouragement and impetus to renewed effort. If we would create a future of which we shall not be ashamed we must understand the present, and this we can do only in the light of the past. In other words in our creative efforts we must use the best that tradition has to offer. To this end all available records must be preserved in such a way that they will be available for future reference. From what Professor Bostock writes it appears that Queensland has a wealth of historical material—books, pamphlets, historical photographs and other relics. These are not especially of medical interest. It also has a great deal of material collected by Sandford Jackson; these are chiefly concerned with medical affairs, though as Professor Bostock states, the titles of the documents alone are a recapitulation of early Queensland history. The housing of all this Queensland material is of the utmost importance—museums are inseparable from the study of history. Professor Bostock's appeal for the proper housing of all the available material in Brisbane must not be allowed to fall on deaf ears. Two aspects arise. One has to do with the present state of the Public Library with its wooden shelves and stairs. The other is the suggestion that Sandford Jackson's collected data should be housed

[1] "Encyclopædia Britannica", Eleventh Edition.

permanently in the residence of the first medical superintendent of the Brisbane Hospital—a house which Professor Bostock describes as an architectural gem worthy of retention on artistic grounds. We would urge Professor Bostock to try to persuade the Queensland Branch of the British Medical Association, the Historical Society of Queensland and the other cultural organizations which he mentions to approach the State Government in the matter. The Government of Queensland has shown on more than one occasion that it is not lacking in imagination. We cannot believe that it would refuse to do what lay in its power to foster and create an Australian tradition, in social life generally as well as in Australian medicine.

This discussion cannot close without a reference to museums in general and to medical museums in particular. Museums should cover the whole field of human knowledge. The first museum was founded in the year 280 B.C., and its main object was the promotion of learning. The objects of museums have been described as including record, research and publication. This being so, it is clear that, like most other concerted human efforts, museums will languish and become ineffective unless they are cherished and studied. This is not the occasion for a discussion on the creation, function and use of museums, but the opportunity must be taken of urging on all medical investigators and practitioners the need for the conservation of records, documents dealing with changes and developments in the organization and the practice of medicine, photographs and so on. Even if the Australian Branches of the British Medical Association have nothing in the way of historical record departments, they should all have a repository for important documents which could be classified and used when such departments or embryo museums were established.

Current Comment.

INFESTATION WITH OXYURIS VERMICULARIS.

THE worm *Oxyuris vermicularis*, also known as *Enterobius vermicularis*, the pin-worm or thread-worm, is one of the commonest of intestinal parasites, and though its presence is not dangerous to life, it is responsible for much discomfort and ill health. The first account of the finding of thread-worms in the appendix was that given by G. F. Still in 1899. Subsequent studies on the incidence of oxyuriasis of the appendix have shown a wide variation. John R. Schenken and Emma S. Moss[1] suggest that this may be due to the varying efficiency of methods used. They have searched for thread-worms in a series of 1,000 appendices removed at operation in the Charity Hospital of Louisiana at New Orleans. The incidence of oxyuris infestation in the entire group was 23·3%. The racial incidence was interesting; 42·1% of the appendices from white women and 38·3% of those from white men were infected, while only 10·1% of those from Negro women and 12·8% from Negro men showed infection. The methods used may be quoted.

Following gross examination of the appendix, the complete content was delivered into a test tube and thoroughly emulsified in water. In the first 600 cases, the specimen was centrifugalized for one minute at about 500 revolutions per minute, after which the supernatant fluid was discarded. In the remaining 400 cases, the same procedure was employed except that centrifugalization was repeated until the supernatant fluid was clear. In both groups the entire sediment was transferred to slides and cover slips were applied.

In the second group, evidence of the presence of oxyuris was found in 31·2%; Schenken and Ross believe that this represents the incidence more truly than the figures given for the whole group.

The predominance of *Oxyuris vermicularis* infection in female patients is emphasized by most authors. It is obvious, of course, that the vagina offers an additional site of infection. That this is so is shown by various records of the finding of oxyurids in the vagina, in the cervix and within the tubal lumen. B. Chomet[1] has recently described a case of *Oxyuris vermicularis* infection of the wall of a Fallopian tube. Froriep, quoted by Chomet, had distinguished two ways in which oxyuris might migrate into a Fallopian tube: (*a*) by the genital canal and (*b*) by a perforation of the intestine or the appendix. Both possibilities are to be reckoned with in the case described by Chomet, for his patient, a white woman, aged thirty-two years, had been admitted to hospital previously after having been shot in the buttock, wall of chest, right flank and abdomen. She had recovered without operation and without clear indication of peritonitis. Seven months later she was readmitted to hospital, complaining of a feeling of pressure in the lower part of the abdomen. A mass could be felt, and at operation her right Fallopian tube and ovary were removed because of adhesions. She made a good recovery. Six months later she was admitted to hospital again, complaining of continuous backache, pain in the left side of the pelvis and dysuria. Enlargement of the left adnexa was present with some tenderness. At operation, the left ovary and tube were found bound down by dense adhesions, and were removed. The fimbriated end of the tube was obliterated and in this region the tube was firm and fibrotic; near the end there were a few small yellowish-white firm nodules. Sections of two of these nodules showed that they were made up of extensive granular necrotic tissue. The periphery of the nodule showed a thin layer of somewhat vacuolated fibrous tissue with moderate numbers of fibroblasts, lymphocytes, plasma cells and eosinophile cells. Within this layer there were a few giant cells, some of which were of the foreign-body type, while others closely resembled the Langhans type of giant cell. The centres of the nodules showed numerous typical ova of *Oxyuris vermicularis* with well-defined cuticle. The author gives his reasons for believing that in spite of the history of gunshot wounds, infection was due to transport from the lower genital canal.

The extent of the possible migrations of oxyuris make it important to treat infections as early as possible. Treatment is by no means satisfactory. Administration of gentian violet by mouth in enteric-coated tablets is the best form of treatment known at present. Phenothiazine, once strongly recommended by Manson-Bahr, has been shown to be far too dangerous. There is some evidence that administration of vitamin *A* renders the mucous membrane of the alimentary tract less likely to harbour the parasite. There is certainly some support for the view that the mucous membrane of the alimentary tract, from the oral orifice downwards, varies greatly in different persons in its liability to "colonization" with bacteria and other parasites. In this connexion, the strikingly higher rate of infection of the appendix in the white patients as compared with Negroes comes to mind. There may be some difference in the general make-up or food habits of the two groups which can account for this. The difference, if it could be found, might provide another weapon for use against that tiny but prolific and troublesome parasite, the pin-worm or thread-worm.

HÆMORRHAGIC PROBLEMS IN CHILD SURGERY.

HÆMORRHAGE is the most obvious and nowadays, apart from sepsis, the most serious complication of surgical procedures. It is most dangerous when it is unexpected. Particularly is this true in regard to infants and children; a loss of 30 cubic centimetres of blood by an infant is equivalent to about a loss of 500 cubic centimetres or more by an adult and the consequences are more deep seated.

[1] *American Journal of Clinical Pathology*, October, 1942.

[1] *Archives of Pathology*, October, 1942.

I. Newton Kugelmass[1] believes that every child about to undergo a major or a minor operation, whether regarded as a good or poor risk, is entitled to "an evaluation of the functional status of all tissues of his body" and especially of the tissues concerned in the clotting of the blood. This is rather a large order, but not too large, when one remembers that serious or even fatal hæmorrhage may occur, quite unexpectedly, after tonsillectomy or even after circumcision. "Knowledge of the child's hæmorrhagic status pre-operatively is equivalent to half the therapy necessary to prevent post-operative bleeding", writes Kugelmass, and the idea is a clear and sound one, even if the language that clothes it is somewhat involved. He tackles the problem in whole-hearted and thorough fashion. Three types of children may present difficulty: the child needlessly considered a "bleeder" invariably has some disturbance of the blood clotting or vascular mechanism; the child with some latent hæmorrhagic tendency will be recognized from the history despite negative response to the routine use of tests; the child with active hæmorrhagic disease is, of course, the most serious problem.

Superficial and half-hearted investigations are worse than useless. As Kugelmass wisely observes, signs of hæmorrhagic disease vary widely and are as individual as the particular patient. "The more accustomed one is to seeking similarities in the diagnosis of disease, the more is one eluded in such attempts at patterning pictures of hæmorrhagic entities." Disturbances resulting from diminution in blood clotting substances constitute one large group of true hæmorrhagic diseases, while those resulting from changes in the vascular endothelium make up another. Moreover, the condition may be hereditary or acquired, primary or symptomatic, transient or permanent. As always, the clinical history is of primary importance. Significant points, besides a history of bleeding or of a familial tendency to bleeding, are dietary deficiency, recent infection or drug therapy. A thorough physical examination should include examination of skin and mucous membranes for petechiæ, ecchymoses, telangiectases, jaundice or evidence of anæmia; palpation of peripheral and deep lymph nodes, spleen and liver; examination of eye-grounds for hæmorrhage or infiltration, and of bones for localized tenderness. If there is the slightest suspicious circumstance in history or examination, a blood examination is, as Kugelmass puts it, crucial. The clotting mechanism involves four substances. "Prothrombin, formed in the liver, combines with thromboplastin, liberated by platelets, to form thrombin in the presence of calcium ions. And fibrinogen formed in the liver is converted by thrombin into fibrin." In Kugelmass's opinion, from the surgical point of view, neither fibrinogen content nor calcium ion deficiency are important. He states that fibrinogen deficiency never causes bleeding and that calcium deficiency to the extent of one milligramme per 100 cubic centimetres of serum will induce tetany, but no hæmorrhage. The important things, therefore, are a blood count, to exclude obvious blood dyscrasia, and tests for deficiency of prothrombin, of platelets, or of thromboplastin, and for the diagnosis of vascular deficiencies. The tourniquet test is an excellent indicator of capillary resistance. Kugelmass gives an exhaustive and very interesting survey of the various conditions that may cause any of these deficiencies.

As to treatment, the best method of treating hæmorrhage is to prevent it before operation. Kugelmass is sure that this can very often be done. A correct diagnosis is all-important. It is, for instance, of no use to expect to control platelet-deficiency hæmorrhage by providing vitamin *K*. As a rule bleeding is due to lack of prothrombin, of platelets or of thromboplastin, and the various forms of these deficiencies can and should be treated before operation, unless the operation is one of supreme urgency. Of course, in some thromboplastin deficiencies, such as hæmophilia, surgical interference involves tremendous risk. Nevertheless Kugelmass avers that minor and even major operations may be undertaken if a large transfusion is given before operation and blood is kept in readiness for transfusion afterwards if necessary. Plasma transfusion may be of use since the deficiency is one of thromboplastin. Treatment of bleeding due to vascular deficiencies depends on their cause; nutritional purpura responds promptly to oral or parenteral administration of the deficient vitamins, B_1, *C* or *P*.

Altogether Kugelmass has written a good review of an important subject. The language seems to be unnecessarily stilted, polysyllabic and obscure, but even if his manner is perhaps not to be imitated, his gravity, earnestness and uncompromising thoroughness may be admired. Any surgical operation is an ordeal and involves a certain amount of risk; when the operation can wait a little while, no time and trouble should be spared in making the patient absolutely "fighting fit". Kugelmass quotes Moynihan's dictum: "Surgery has been made safe for the patient; we must now make the patient safe for surgery." This is especially true when the patient is a child.

[1] *The American Journal of Pathology*, September, 1942.

STERILIZATION OF THE SKIN.

THE attainment of aseptic surgery has not been fully realized, partly because of the impossibility of sterilizing the patient's skin. The futile belief that the use of repeated preparations, perhaps extending over several days and perhaps embodying strong antiseptics, and the use of side towels on a wound will prevent the contamination of the wound by organisms from the skin or sweat glands, is held by many surgeons. The repeated application of antiseptic agents, whether dehydrating or not, often results in a sodden condition of the skin probably due to the retention of sweat beneath the occlusive dressing towels. If they had any say in the matter the organisms from the sweat glands would surely be pleased to find such an environment instead of the usually protective, dry, keratinized layer of the skin. The irregular surface of fabrics, however fine, must traumatize the delicate tissues of the body. One has only to view their rasp-like appearance under the microscope to realize this. Unless otherwise advantageous, it would seem preferable not to subject the wound to such punishment. The rapidity with which sweat and its contained bacteria will diffuse through side towels and the fact that, unless securely fixed at many points, side towels are apt to shift a little and to sweep the organisms from the skin in juxtaposition to the wound into the depths of the wound, make the use of side towels of doubtful value.

The problem of aseptic surgery has now resolved itself into the reduction of contamination to an absolute minimum, together with the practice of atraumatic surgery, there being a definite relationship between trauma and the development of infection. It would well be if this were better realized, especially by those surgeons with orthopædic leanings, for there is no sense in an elaborate ritual to prevent infection if the wound will assuredly contain a hæmatoma in which organisms from some focus, septic or otherwise, may subsequently lodge and multiply. Incidentally, many surgical masks are woefully inadequate.

A self-sterilizing, impermeable, non-irritating skin varnish to be applied to the operative field would seem to satisfy the demands of those optimists who attempt to sterilize the skin of the patient. Arthur D. Ecker[1] has used a cellulose varnish for this purpose; it is said to possess the properties referred to above and can be easily redissolved at the end of the operation. It is also said to be non-toxic and apparently does not interfere with the operation or with the healing of the wound. Ecker conducted a small number of laboratory experiments which demonstrated the beneficial results obtained by the use of this skin varnish in diminishing the number of organisms on the surface or brought to the surface by the sweat. He has used his skin varnish in only forty major operations, but the premature publication of the method was made to allow investigation in larger surgical clinics. It is to be hoped that such investigations will be carried out, for the results obtained in a larger series of cases will be awaited with interest.

[1] *Surgery*, October, 1942.

Abstracts from Medical Literature.

DERMATOLOGY.

Primary Lesions of Pemphigus Vulgaris.

M. OPPENHEIM AND D. COHEN (*Archives of Dermatology and Syphilology*, August, 1942) discuss the question whether, like syphilis, pemphigus begins with a primary lesion some time prior to the generalized eruption. In the majority of cases, if not in all, *pemphigus vulgaris* begins with a primary lesion, and often this is characteristic. The authors mention Leszcynnske, who in 1930 collected the facts on primary lesions of *pemphigus vulgaris* and who stated that the chronic type usually begins in the mucous membrane of the mouth, with erosions, blisters and blebs, croupous aptholds and *stomatitis ulcerosa*. He observed a primary lesion on the scalp. One of the authors (Oppenheim) in 1930 stated that prior to the generalized bullous eruption and the development of the vegetations in the axilla, on the genitals and on the scalp, a localized rash may appear in the mouth. This is characterized by bullæ unassociated with inflammation; it is resistant to treatment, and it tends to recur. Since 1930 Oppenheim has obtained a history of primary lesion in many cases of *pemphigus vulgaris* observed in Austria.

Bullous Dermatitis Herpetiformis.

M. H. GOODMAN (*Archives of Dermatology and Syphilology*, August, 1942), during a period of five years, collected a series of fifteen cases of bullous type of *dermatitis herpetiformis*. This has been relatively frequent in persons over fifty years of age. In the corresponding period he encountered only five cases of proved *dermatitis herpetiformis* in the young adult group (aged sixteen to fifty years). The lesions tend to be almost exclusively bullous and the bullæ range from the size of a pea to that of a hen's egg. Although the eruption may be extensive there is a greater tendency toward localization than in typical *dermatitis herpetiformis* and also toward annular grouping of the bullæ. There occurs in most cases, as the disease progresses, a coalescence of the bullous elements to form peculiar inflammatory plaques, at the periphery of and on which fresh bullæ continue to form. In most cases the condition responds to arsenical therapy. Vitamin *D* seems to have some value in controlling the disease. Because of its special features and the tendency for lesions to develop in the flexures and intertriginous areas, the disease may offer some difficulty in differential diagnosis and has apparently often been mistaken for pemphigus. However, pemphigus occurs most frequently in the age groups from twenty to fifty years. It is suggested that all cases, especially in patients about or over the age of fifty years, which were previously recorded as instances of controlled or cured pemphigus, should be reviewed in the light of the findings in the author's series of cases.

UROLOGY.

Porphyria.

H. L. CORRELL, B. J. PETERS AND F. D. MURPHY (*Urologic and Cutaneous Review*, June, 1942) report two cases of porphyria, the acute phase of which is characterized by the excretion of porphyrins in the urine, and these give the latter a deep "port-wine" colour. The porphyrins excreted are hæmatoporphyrin, and the term "porphyria" is suggested for the whole disease, as being more correct. There are three main types of the disease: congenital, acute and toxic. The two cases presented are of the acute fatal idiopathic type, and the authors wish to emphasize that its consideration should not be omitted in acute abdominal diseases. Suspicion of the disease should be aroused in patients with acute abdominal pain, ileus and fever, at times accompanied by polyneuritis and psychotic episodes, in whom a history of previous similar attacks, with port wine urine, is given. Females are affected in three-quarters of all cases, and the onset is commonest in the third or fourth decades of life. The mortality in the more serious attacks is about 50%. The congenital type is often familial, but not hereditary; the chief manifestations are bullous skin lesions, pigmentation, pink staining of the teeth, photosensitivity and reddish urine. In the acute and toxic types, gastro-intestinal and nervous symptoms are characteristic. The toxic type is said to result from the use of veronal, trional, sulphonal or related drugs.

Diverticulum of the Ureter.

WITH an exhaustive review of the literature E. H. Richardson (*The Journal of Urology*, May, 1942) records an additional case of ureteral diverticulum. There were no signs or symptoms suggestive of disease of the urinary tract; the diverticulum originated from the middle third of the ureter and contained 3,500 cubic centimetres of urine. Despite resection of seven centimetres of ureter with the diverticulum, the remainder was sufficiently redundant to permit end-to-end anastomosis with subsequent restoration of normal function on the involved side.

Conservation of the Hydronephrotic Kidney.

E. G. BALLENGER AND H. P. MCDONALD (*The Journal of Urology*, March, 1942) state that there are still too many surgeons who have not tried to master the difficulties attendant on the surgical relief of obstructions at the ureteropelvic juncture, and who therefore perform nephrectomy as a routine measure when even minor degrees of hydronephrosis are present. This attitude is incorrect, and correct retrograde pyelographic study, with functional tests, will give the surgeon an almost exact estimate of whether the kidney is worth saving before operation is attempted. Complete retrograde uretero-pyelography is essential, and a simple pyelography alone is not sufficient. The most important factor in conservative operations at the outlet of the renal pelvis is removal of the obstructing agent, be it aberrant vessels, bands and adhesions, or both. An aberrant vessel can be safely divided unless it is large. All other irregular bands, adhesions and vessels are similarly divided and the whole of the uretero-pelvic area is cleaned up thoroughly and straightened out so as to recover its normal "trumpet" shape. When this is done, it is sometimes noted that the actual junction is very narrow. For this deformity, the Heineke-Mikulicz principle of longitudinal incision with transverse suture has given an excellent result in the authors' hands, though many others have reported unfavourably. An alternative method, giving good results also, is the Y-plasty of Schwyzer, in which the stem of the Y runs through the juncture longitudinally, and the two arms radiate upwards on the pelvic wall; the point of the resulting V-flap of pelvic wall is drawn down and sutured into the juncture so as to widen it. Nephrostomy drainage and temporary splinting of the ureter are valuable adjuncts to the operation, as also is nephropexy.

Treatment of the Contracted Bladder.

M. M. PARKER (*The Journal of Urology*, April, 1942) has described an original method of treatment for contracted bladder. In discussing the ætiology, he points out that reduction of bladder capacity in acute cystitis is an escape phenomenon which tends to produce a vicious cycle. Fibrosis of the bladder wall is a late feature, the earlier phases being neuro-muscular in origin. The author tested the capacity of his patient's bladder with and without spinal analgesia, finding that anæsthesia doubled the volume. After attempting other methods without success, he made a transsacral exposure of the lower sacral nerve roots and divided the posterior root of the third sacral nerve on each side. Anæsthesia in these areas resulted, but the patient was immediately freed from pain on micturition and bladder capacity gradually increased to eight ounces after six months. The author points out that the operation is experimental and that it is most important that no gross irritative lesion of the bladder be treated by this method.

Urinary Incontinence in the Female.

C. B. BRACK (*Urologic and Cutaneous Review*, May, 1942) states that if the incontinent or excessive type of frequency due to infection is excluded, incontinence of urine in the female may be due to mechanical lesions of the sphincter, or to neurological lesions. The mechanical sphincter lesion is most commonly a relaxation of this muscle, and may be associated with cystocele. The actual cause is injury to the floor of the urethra, sustained in childbirth. The incontinence is usually incomplete and of the "stress" type, that is, it is absent when the patient is recumbent, present when she is up and about to some degree, but much worse when she coughs or sneezes. With the patient lying down, if the bladder is filled with fluid, and the patient is asked to cough vigorously, some fluid will be seen to escape. Cystoscopy reveals a normal-looking bladder, and on slow withdrawal of the cystoscope the sphincter is seen to close symmetrically. Cystometric study gives a normal curve, and thus rules out a neurological lesion. The treatment is plastic repair of the sphincter. A neurological lesion is either motor or sensory. A common

motor type occurs with *spina bifida*, associated with a developmental abnormality of the anterior sacral roots; nocturnal enuresis of childhood is sometimes caused by a similar lesion. It is important to remember that, both in children and female adults, a functional or psychological incontinence can occur, but in such cases cystometric study gives a normal graph. In these motor lesions the bladder capacity is small, often less than 100 cubic centimetres. Prominent rhythmical contractions of the vesical muscle are seen throughout the graph, and these tend to increase in amplitude as filling of the bladder with the test fluid proceeds. Any lesion of the cortico-afferent pathways may produce similar trouble, with great frequency or even incontinence, a small bladder, and greatly increased vesical pressure when small quantities of fluid are introduced. The treatment of the motor lesions is mainly medical. Belladonna, or one of its derivatives, is given up to the limit of tolerance. If that fails, a sympathetic stimulant like ephedrine is given in 25-milligramme doses every eight hours and usually by injection. A typical sensory neurological lesion is *tabes dorsalis*, in which the damage causing the vesical trouble is in the sacral posterior roots. The patient is unable to tell when the bladder is full. The muscle tone is decreased by the nerve lesion, and still further decreased by over-distention of the bladder. Residual urine gradually accumulates. The bladder capacity is very large, and, as more and more fluid is introduced in cystometric study, there is very little increase of pressure, and there are no contraction waves capable of emptying the bladder. The patient should be instructed to try to empty the bladder every two hours, whether she feels desire or not. Pure sympathetic stimulants such as acetyl-β-methylcholine, in doses of 0·2 gramme by mouth twice daily for repeated courses of one week each, may cause residual urine to decrease in amount. Regular bladder irrigations help, and some writers advise tidal drainage at a low level of pressure.

Diethylstilbœstrol in Prostatic Carcinoma.

P. J. KAHLE, H. D. OGDEN AND P. L. GETZOFF (*The Journal of Urology*, July, 1942) recall that in 1940 one of the authors (P. J. Kahle) reported treatment of benign prostatic hyperplasia by means of diethylstilbœstrol and diethylstilbœstrol dipropionate with excellent clinical effects. Histological studies of tissues from three patients who died from unconnected causes showed reduction in the height of epithelium, reduction in the number of papillary infoldings, vacuolization of cytoplasm and decrease in size of acini. This success suggested that the same œstrogenic substances might be beneficial in carcinoma of the prostate. Seven cases of proved carcinoma of the prostate are included in this study. The studies up to date provide no evidence that this disease can be cured by the intramuscular injections of these drugs, but it has uniformly been found that the lesions regress and remain latent, and that life can be prolonged in comfort. Freedom from pain and restoration of general activity are benefits which cannot be ignored. The mechanism by which these œstrogenic substances act is not well understood. In recent years it has been determined that castration eliminates gonadal androgens with consequent retrogressive changes in prostatic carcinoma. Injection of œstrogenic substances may have a similar effect, perhaps with the hypophysis as intermediary. Retrogressive changes after these injections were not confined to the primary growth, but were observed in the bones and lymphatic glands (metastatic sites).

J. R. SCHENKEN, E. L. BURNS AND P. J. KAHLE (*ibidem*) report on the cytological changes in six cases of carcinoma of the prostate treated solely by stilbœstrol. The cases are those described in the same journal by Kahle, Ogden and Getzoff. The total dosage varied from 52 milligrammes to 95 milligrammes and the duration of treatment from 25 to 46 days. Biopsies were made by means of the resectoscope from different portions of the prostate, both before and after treatment. Most of the neoplastic cells in each of the cases showed definite nuclear and cytoplasmic regressive changes. The nuclear changes consisted of reduction in size, progressive condensation of the chromatin, loss of nucleoli, loss of mitotic figures and pyknosis. In the cytoplasm, vacuoles appeared, gradually enlarged, and later displaced the nuclei towards the lumen of the acinus. This was followed by rupture of cell membranes, and coalescence of vacuoles of contiguous cells. The nuclei were often extruded into the acinus. In three out of the six cases a few scattered neoplastic cells were found to be unchanged. Similar regressive changes were also noted in one case in metastatic lesions in inguinal lymph glands. The regressive changes described above are quite unlike those due to irradiation. The authors have no information as yet regarding the effect of stilbœstrol upon malignant tissue other than carcinoma of the prostate.

RADIOLOGY.

The Significance of the Radiological Manifestations of Erythema Nodosum.

PETER KERLEY (*British Journal of Radiology*, June, 1942) discusses *erythema nodosum* and reports twelve cases of the malady. He states that patients with *erythema nodosum* usually present no pulmonary symptoms or signs, and that the majority recover quickly and completely. Occasionally fever or other manifestations are prolonged, and in a large proportion of these cases X-ray examination reveals massive enlargement of the bronchial glands, with or without infiltration of the lungs. In all the author's cases this enlargement of the bronchial glands was present. A feature of *erythema nodosum* which does not appear to have been recorded previously is the occurrence of a benign miliary infiltration of the lungs, which may occur simultaneously with the glandular enlargement, or may not appear for some months. This infiltration was found in eight out of twelve cases. A detailed study of the appearances in these twelve cases showed that they were identical with those found in the sarcoidosis of Boeck. Clinical and pathological findings in some of the cases provided additional evidence of a relationship between *erythema nodosum* and Boeck's sarcoid. The widespread manifestations of sarcoidosis when it is first seen, would suggest that it runs a sub-clinical course for some time. This page in the life history of the disease may be filled in by an analysis of cases of *erythema nodosum*. The pulmonary infiltration is of two types. In the first the foci are round or oval, vary considerably in size, but average three millimetres in diameter. The foci are larger, denser, and more sharply defined than those seen in miliary tuberculosis. They are usually less numerous and more widely spaced than the foci of miliary tuberculosis. They do not decrease in size towards the periphery. Often they are larger at the periphery than near the hilum, and their distribution does not correspond to the smaller divisions of the bronchial tree. The whole of both lungs may be studded or only one lobe or one segment may be involved. The foci do not coalesce, but occasionally they cause a large or small focal atelectasis, which should not be mistaken for coalescence. The only anatomical basis on which an uneven miliary lesion of this type can be explained, is that the nodes are in lymphoid tissue. The second type of lung infiltration is more difficult to describe, although it is equally striking. There is a coarse, reticular striation radiating from the hila. These striæ do not follow the normal ramifications of the pulmonary vascular system, and diminish little in size towards the periphery. They are easy to distinguish from blood vessels because they are denser, longer, and straighter, and seldom bifurcate. A close inspection of the picture shows that in addition to these striæ there are numerous minute round foci, less dense than end-on vessels or tubercles, and indeed to be detected only on a good quality radiograph. Here and there one may see a few larger nodes similar to those of Type 1. A similar appearance is seen in advanced cases of congestive failure and in *lymphangitis carcinomatosa*, and doubtless these striæ in *erythema nodosum* and sarcoidosis are similarly due to congested or blocked lymphatics. The minute round foci of slight density represent end-on lymphatics. One or other type of infiltration predominates in any given case, but some of the features of both types are always present. Both types of lung infiltration are associated at some period of the disease with massive enlargement of the bronchial glands, and available evidence suggests that the glandular enlargement precedes the lung infiltration.

Bone Infarcts.

S. C. KAHLSTROM (*American Journal of Roentgenology*, March, 1942) states that the radiological features of infarcts of the diaphysis are quite characteristic, with well-defined, often symmetrical mottled areas of increased density involving the medullary portions of the diaphyses, sometimes extending into the epiphyses. Involvement of the non-articular cortex is infrequent. The size varies considerably. The larger lesions are often separated from the normal bone by a narrow zone of calcification, and frequently contain cystic areas with surrounding calcification. The necrotic bone may become completely calcified, leaving a homogeneous, dense, non-reticulation defect.

British Medical Association News.

ANNUAL MEETING.

THE annual meeting of the Queensland Branch of the British Medical Association was held at British Medical Association House, Wickham Terrace, Brisbane, on December 11, 1942, DR. F. W. K. LUKIN, the President, in the chair.

ANNUAL REPORT OF COUNCIL.

The annual report of the Council, which had been circulated among members, was taken as read on the motion of Dr. L. P. Winterbotham, seconded by Dr. D. Gifford Croll, and was adopted on the motion of Dr. H. W. Horn, seconded by Dr. L. P. Winterbotham. The annual report is as follows.

The Council has pleasure in presenting the following report of the work of the Branch for the year ending November 15, 1942.

Membership.

The membership of the Branch is 563, as against 539 last year, making a gain of 24. Two honorary members and four honorary associate members were elected during the year.

The gains were: new members, 32; transferred from other Branches, 8; members reinstated, 3.

The losses have included: members transferred to other Branches, 8; deceased, 3; default in payment of subscription, 10.

The Branch has sustained a loss by death of the following members: Dr. E. Elmslie Brown, Dr. F. C. Bechtel and Dr. D. V. Sheil.

There is a total of 210 members engaged on full-time duty with His Majesty's Forces.

Honours have been conferred by His Majesty the King on the following members for services rendered during the present war: Captain J. J. Ryan, M.C.; Major A. Fryberg, M.B.E.; Surgeon Lieutenant D. C. Jackson (R.N.V.R.), D.S.C.

Meetings.

General.

In addition to the annual meeting, ten meetings of the Branch were held, including three clinical meetings. The average attendance was forty-one.

Council.

Nineteen ordinary and one special meeting of the Council were held. The record of attendances of the Council is as follows:

	Ordinary.	Special.
Dr. F. W. R. Lukin (President)	19	1
Dr. Alan Lee (President-Elect)	19	1
Dr. J. G. Wagner (Past President, Honorary Treasurer, and Honorary Secretary of Subcommittees)	16	1
Dr. Herbert Earnshaw[1] (Honorary Secretary)	1	—
Dr. H. W. Horn (Chairman of Committees)	19	1
Dr. Felix Arden (Councillor)	15	—
Dr. J. G. Avery[2] (Councillor)	7	1
Dr. D. Gifford Croll (Federal Council Representative and Councillor)	8	1
Dr. L. H. Foote (Councillor)	11	—
Dr. Milton Geaney[3] (Councillor)	10	1
Dr. Basil L. Hart (Councillor)	14	—
Dr. L. T. Jobbins[4] (Councillor)	8	1
Dr. S. F. McDonald (Councillor)	16	1
Dr. A. Eric Mason[5] (Councillor)	1	—
Dr. Alec. E. Paterson[6] (Councillor)	7	1
Dr. Mervyn S. Patterson (Councillor)	8	—
Dr. T. A. Price (Vice-President of the Branch, Federal Council Representative and Councillor)	5	—
Dr. J. Lloyd Simmonds (Councillor)	12	—
Dr. W. H. Steel (Appointed Honorary Secretary May 22, 1942)	18	1
Dr. N. C. Talbot[7] (Councillor)	—	—
Dr. L. P. Winterbotham (Councillor)	18	—

[1] On leave of absence—resigned June 12, 1942.
[2] Appointed June 26, 1942.
[3] Appointed June 12, 1942.
[4] Appointed April 24, 1942.
[5] Resigned July 10, 1942.
[6] Reelected July 24, 1942.
[7] Resigned April 10, 1942.

Scientific.

February.—Sir Raphael Cilento: "A Salaried Medical Service for Australia."

March.—Dr. T. A. Price: "The Federal Council Proposals for a National Medical Service."

April.—Dr. Alan E. Lee: "Need there be a Revolution in Medical Practice?".

May.—Major A. W. L. Row: "Military Medicine."

June.—Dr. F. M. Burnet: "The Story of Rickettsial Disease in Australia" (Joseph Bancroft Memorial Lecture).

July.—Clinical meeting combined with the Brisbane Women's Hospital Clinical Society.

August.—Clinical meeting combined with the Hospital for Sick Children Clinical Society.

September.—Professor John Bostock: "The Place of History in War and Post-War Problems" (Jackson Lecture).

October.—Lieutenant-Colonel Maurice Pincoffs, U.S.A.-M.C.: "Clinical Varieties of Arterial Hypertension."

November.—Clinical meeting combined with the Mater Misericordiæ Public Hospital Clinical Society.

Office Bearers and Councillors.

Dr. Alan E. Lee was elected President-Elect for the ensuing year and Dr. Herbert Earnshaw was elected Honorary Secretary, but owing to military duties he resigned and Dr. W. H. Steel was appointed to fill the vacancy.

The following office bearers were elected by the Council:

Honorary Treasurer: Dr. J. G. Wagner.

Chairman of Committees: Dr. H. W. Horn.

Honorary Secretary of Committees: Dr. J. G. Wagner.

Honorary Librarian and Curator of Museum: Dr. Neville G. Sutton.

Assistant Honorary Librarian: Dr. Konrad Hirschfeld.

A number of changes took place in the personnel of office bearers and councillors during the year.

Dr. A. Eric Mason and Dr. N. C. Talbot resigned owing to military duties and Dr. J. G. Avery, Dr. Milton Geaney and Dr. L. T. Jobbins were appointed to fill the vacancies.

Dr. Alec. Paterson found it necessary to resign from the Council owing to military duties, but was later reelected to fill a vacancy which had occurred in the interim.

Ethics Committee.

At the annual meeting of the Branch held on December 12, 1941, the following were elected members of the Ethics Committee: Dr. Alex. Marks, C.B.E., D.S.O., V.D., Dr. G. P. Dixon, C.B.E., V.D., Surgeon Commander Gavin Cameron, Dr. M. Graham Sutton, Dr. L. J. J. Nye.

No matters were dealt with by the committee during the year.

Library.

During the year fifty books were borrowed from the library by twenty-one members.

It is pleasing to note that the library has been well patronized by medical officers of the United States Army and by members of the Australian Army Medical Corps from other States stationed near Brisbane.

Book Pool.

In view of requests received from medical officers of the armed forces, a pool of books and periodicals has been set up. These books are housed at the Medical School Library, from where they are redistributed in response to requests received, the cost being borne by the Branch. Members who are prepared to give medical journals and books to the pool have been requested to send them to the Medical School or the Branch office.

The following books have been presented to the library from Professor H. J. Wilkinson and Dr. G. W. Mason respectively: *The Lancet*, Volume I, 1904, and "Otosclerosis"—Guggenheim.

Representation.

The Branch was represented as follows during the year:

Council of the British Medical Association: Professor R. J. A. Berry.

Federal Council of the British Medical Association in Australia: Dr. T. A. Price, Dr. D. Gifford Croll, Dr. Alan E. Lee.

Federal Council, Contract Practice Committee: Dr. T. A. Price.

Australasian Medical Publishing Company Limited: Dr. D. Gifford Croll.

Medical Officers' Relief Fund (Federal): Queensland Committee, Dr. D. Gifford Croll, Dr. G. P. Dixon, Dr. W. H. Steel.

Medical Assessment Tribunal: Dr. A. H. Marks.

Queensland Medical Board: Dr. D. Gifford Croll, Dr. H. W. Horn and Dr. J. G. Wagner.

Queensland Post-Graduate Committee: Dr. S. F. McDonald, Dr. E. S. Meyers, Dr. Alex. Murphy, Dr. N. W. Markwell, Dr. Alan E. Lee, Dr. J. Lloyd Simmonds.

Queensland Cancer Trust: Dr. Alan E. Lee, Dr. Konrad Hirschfeld.

Queensland Nutrition Council: Dr. P. A. Earnshaw, Dr. Noel M. Gutteridge.

Queensland Medical Coordination Committee: Dr. F. W. R. Lukin.

National Safety Council: Dr. Herbert Earnshaw.

Queensland Bush Nursing Association: Dr. L. Bedford Elwell.

Standards Association of Australia: Dr. E. O. Marks.

Australian Aerial Medical Services: Dr. Harold Crawford.

Red Cross Society Blood Transfusion Service Committee: Dr. Milton Geaney.

The Surf Life Saving Association of Australia, Queensland State Centre: Dr. F. W. R. Lukin.

Physical Fitness Association of Queensland: Dr. E. S. Meyers and Dr. Harold Crawford.

The Editor of THE MEDICAL JOURNAL OF AUSTRALIA was represented by Dr. Joyce Stobo.

Subcommittees.

Hospital.

Personnel: Dr. S. F. McDonald, Dr. L. P. Winterbotham, Dr. D. Gifford Croll, Dr. Felix Arden and the *ex officio* members of the Council.

Very little business was dealt with in connexion with hospitals during the year.

One member arrived at an agreement with his Hospital Board concerning the definition of a "private patient", namely, that all persons entering a private ward are liable to be charged at the rates set down for medical fees in accordance with a schedule.

Organization.

Personnel: Dr. D. Gifford Croll, Dr. A. E. Mason, Dr. Felix Arden, Dr. J. L. Simmonds and the *ex officio* members of the Council.

Twenty-three meetings were held and a variety of subjects were considered and recommendations made to the Council.

The following are some of the matters on which action was taken by the Council, and which are not referred to under separate headings in this report:

Insurance Certificates.—An inquiry was received concerning the fee payable for insurance certificates on small forms to which a reply was sent to the effect that the Council is of the opinion that 10s. 6d. is not a sufficient fee for any insurance examination, irrespective of the size of the form used, as a complete examination is necessitated in all cases. The insurance company in question was requested not to submit the small form to our members, and agreed to refrain from doing so in future.

Re Fee for Locum Tenens.—The opinion was expressed by the Council that it is considered the fee for *locum tenens* should be £12 12s. per week.

Australian Broadcasting Commission: Nutrition and Diet.—Dr. Noel M. Gutteridge represented the Branch at a conference of interested bodies held in Sydney on January 8, which was organized by the Australian Broadcasting Commission, to draw up a programme on nutrition and diet for broadcast talks.

Men's Dress Reform.—The committee appointed to deal with this question is still functioning and inquiries have been received from a naval medical officer concerning the movement. Owing to the men in the services being issued with summer uniforms for the tropics, suitable men's clothing for hot climates will probably be universal after the war.

Advertising.—The Council has had to inform several members who made inquiries, that circularizing patients regarding change of hours, or for any other purpose without permission of the Council, is contrary to the By-laws of the Branch.

Fees for Medico-Legal Evidence.—The Department of Justice has been approached concerning the remuneration of medical practitioners who are called upon by the police to give medical evidence. (General information on this subject is published in the "British Medical Agency of Queensland Handbook".)

The Department of Justice has advised that a fee of £1 *per diem* is the rate of payment laid down, and where a witness is obliged to use his own car by reason of there not being the usual means of conveyance available he will be entitled to receive mileage at the rate not exceeding 6d. for every mile after the first two miles actually travelled in going to, and the first two miles in returning from the court. When a medical practitioner travels in his own car to view a dead body for the purpose of making a superficial examination or holding a post-mortem examination under the *Coroners Act*, he shall be entitled to receive mileage at the rate of 1s. 8d. per mile after the first two miles each way.

This is considered to be inadequate and the Minister for Justice is being approached with a view to having a more equable method of computing remuneration for such professional service devised.

Medical Fees Tribunal.—Only one case was referred to this body during the year and the finding was "that the fee charged was fair and just".

Historical Records.—A subcommittee has been appointed to collect and preserve historical records and old instruments which might be of interest. The personnel consists of Professor H. J. Wilkinson, Professor John Bostock and Dr. Felix Arden.

Red Cross Society Blood Transfusion Service.—In response to an inquiry the Council was informed that human serum from Red Cross Society stocks for emergency casualties for civilian use is available from depots throughout Queensland. A list of the depots and names of the local representatives was supplied. A clinical report of each case is required to be furnished on a special form to the Red Cross Society Blood Transfusion Service for each administration of serum. As the constitution of the Red Cross Society does not permit of the sale of any of its property, a donation could be made by any private practitioner using the service. Members of the Branch have been asked to cooperate with the Society by encouraging suitable persons to become donors to the blood bank.

"Fatigue" Working Hours.—The question of the effect of long hours on workers at munition factories and other occupations was discussed with the relevant authorities. In an interview by the President with a senior officer of the munition factories a statement was made to the effect that the overtime hours are being gradually reduced.

Medical War Relief Fund.—The proposal of the Federal Council to institute a medical war relief fund was considered and the Queensland Branch expressed the opinion that instead of being an entirely war benefit fund, it should be a federal medical relief fund. The fund should be raised by an increase in the annual subscription rate. Members of the Branch were asked to give their opinion and the majority of the replies were in accordance with the views expressed above. The question of a proposed medical benevolent fund for the State is still under consideration.

Medical Officers Relief Fund (Federal), 1914-1918.—Two beneficiaries in Queensland are receiving assistance from this fund, both of whom are widows of medical officers of the 1914-1918 war.

Subscriptions Payable by Members on Active Service and Full-Time Service with His Majesty's Forces.—After consultation with the auditors of the Branch it was resolved that the subscriptions payable by these members in future be £4 *per annum*, except where a member is entitled to a lower rate in ordinary circumstances. A letter explaining the position as shown by the auditor has been sent to the members concerned, showing the following details:

	£	s.	d.
Amount payable to B.M.A., London, for Journal	1	5	6
Amount payable to THE MEDICAL JOURNAL OF AUSTRALIA less rebate of 10s. for members on full-time service with His Majesty's Forces		10	0
Federal Council contribution		6	0
Branch and organization subscription	1	18	6
	£4	0	0

It will be noted that this leaves a net subscription to the Branch of £1 18s. 6d., which is the greatest reduction that the Branch can afford.

Zinc Oxide and Lead Paint.—As a result of inquiries it was learned by the Council that the restriction of zinc oxide for the manufacture of paint for civilian use in Queensland has been lifted, and zinc paint is now available in this State for domestic purposes. A circular was sent to members drawing attention to this fact in view of the danger of lead poisoning in children from the use of lead paint on surfaces within their reach.

In this regard it is interesting to note that the Operative Painters and Decorators Union made a request for a member to deliver a lecture to members of the Union on the "Incidence of Lead Poisoning from the Use of Lead Paint". The lecture was delivered by Dr. L. J. J. Nye and a letter of thanks was subsequently received from the Union.

Vaccination.—The Council communicated with the authorities advocating compulsory vaccination.

Venereal Disease.—The Council was asked for an expression of opinion concerning the effect of compulsory notification of venereal disease which exists in Queensland under the provisions of the *Health Act*. A reply was sent stating that we are in favour of notification of all infectious diseases with adequate safeguards of the patient's interests. Patients under treatment should be provided with sustenance if their means of livelihood is interfered with. Compulsory notification fails to be of value unless appropriate action is taken by the health authorities, and unless it has the full cooperation of the profession. Also compulsory notification would be much more efficacious if stringent action and heavier penalties were imposed on unqualified persons treating venereal disease.

Treatment of Snake Bite.—A statement drawn up for the treatment of snake bite for first aid based on Dr. Charles Kellaway's research on the subject was submitted to the Council and approved. In view of the large number of men in the field in Queensland it was decided to suggest to the Editor of THE MEDICAL JOURNAL OF AUSTRALIA that Dr. Charles Kellaway's article of October 8, 1938, be revised and republished and that reprints be made available to interested bodies. This suggestion was put into effect.

Treatment of Rape and Indecent Assault on Females.—Members were circularized with regard to the treatment of victims and advice was given on the subject.

The President attended a deputation to the Premier (the Honourable W. Forgan Smith) which was organized by the National Council of Women (Queensland) concerning the question of more attention being given to the very light penalties so often imposed in the case of offences against children and young girls.

Nutrition Pamphlets: Recommended Diet.—A total of over 1,152 pamphlets has been purchased by members of the Branch during the year.

Lodge and General Practitioner Group.

Personnel: Dr. F. W. R. Lukin, Dr. J. G. Wagner, Dr. H. W. Horn, Dr. L. P. Winterbotham, Dr. J. Lloyd Simmonds, Dr. D. Gifford Croll and Dr. T. A. Price. As the personnel of these committees is the same they dealt with all matters relating to contract practice

Capitation Fee (Metropolitan Area).—Advice has been received from the Government Statistician's Office that the lodge capitation fee for the metropolitan area for the year commencing July 1, 1942, has been computed at 29s.

Shortage of Lodge Medical Officers.—The Queensland Medical Coordination Committee has taken steps to meet the situation of the shortage of lodge medical officers in some suburban areas where the need was most urgent.

Medical Benefits for Widows, Orphans and Widowed Mothers of Deceased Soldiers (Repatriation Commission).—With regard to the proposed agreement between the Federal Council and the Repatriation Commission the Branch Council has reaffirmed its opinion, as expressed by the General Practitioner Group of the Branch, in favour of a unit fee instead of a family rate. It is also considered that the principle should be strongly maintained that no concessional rate should ever be taken into consideration in negotiations with Government bodies. The matter is still under discussion.

Federal Form of Lodge Agreement.—Steps are being taken to bring the Federal Common Form of Agreement into force in view of industrial wartime developments.

It was considered that all contract practice should be accepted only through recognized friendly societies and in the terms of the Federal Common Form of Agreement.

Federal Contract Practice Committee.—Dr. L. P. Winterbotham has been appointed as representative of the Branch on this committee for the ensuing year.

Bundaberg Medical Clinic.—This body, which was formed last year to enable patients to have free choice of doctor, is progressing favourably.

Rockhampton Associated Friendly Societies Medical Institute.—A satisfactory agreement has been made by the Rockhampton Local Medical Association with the Rockhampton Associated Friendly Societies Medical Institute and the capitation fee is now varied in accordance with the nominal wage index figure.

Joint Committee.—The representatives of the Council are Dr. F. W. R. Lukin, Dr. T. A. Price and Dr. A. E. Mason. Apart from routine matters the main business dealt with was the provision of adequate medical service for lodge members. This question is now under the control of the Queensland Medical Coordination Committee, which deals with the provision of medical personnel.

War Emergency Organization.

Protection of Practices during War Period.—Wherever possible the Council has taken steps to protect the practices of members on service with His Majesty's Forces. In doing so it is bound by its own set of resolutions for the implementation of the by-law, which include consideration of the public need in any district as well as the interest of members. Since the by-law was passed, the position has changed owing to greater powers being conferred upon the Queensland Medical Coordination Committee which now controls the movements of the medical profession.

Assistance to Members on Active Service.—The British Medical Association scheme for assistance to members on service with His Majesty's Forces which has been operating in the metropolitan area for the past three years terminates at the end of the year in accordance with the agreement. This scheme has met a very great need and without its assistance the families of many of our members would have suffered great financial hardship.

At a meeting of members of the Branch held on November 11, 1942, it was decided that the recommendation of the Council of the Branch be adopted for the continuance of a similar scheme with a limitation of contributions and beneficiaries. Members will be advised of details at an early date.

Assistance schemes are also operating in several districts outside the metropolitan area.

Income Tax: Schemes for Assistance to Members on Military Service.—The Federal Treasurer has advised that funds established to safeguard the practices and augment the incomes of members of the profession engaged on war service will be exempt from payment of income tax for the year ended June 30, 1942.

Medical Practice under War Conditions.—A notice for display in their surgeries has been sent to all members of the Branch enlisting the cooperation of patients by calling the doctor early and by visiting his surgery whenever possible.

Queensland Medical Coordination Committee.—This committee has been reorganized and is vested with increased statutory powers under National Security Regulations. Colonel N. C. Talbot, M.C., E.D., A.A.M.C., Deputy Director of Medical Services, Headquarters, Queensland Line of Communication Area, is the chairman; Dr. J. G. Wagner is deputy chairman and executive officer and Dr. F. W. R. Lukin is assistant executive officer and is the representative of the Queensland Branch of the British Medical Association. The Naval Medical Service is represented by Surgeon Commander Gavin H. Cameron; Group Captain S. F. McDonald represents the Royal Australian Air Force; Sir Raphael Cilento, Kt., M.D., represents the Department of Health and Home Affairs.

The committee, which formerly used the British Medical Association office as its headquarters, has now moved to 113, Wickham Terrace, Brisbane. Miss Nancy Heaslop, who acted as secretary, has joined the W.A.A.A.F.'s and the position is occupied by Miss Thelma Holmes.

A letter was received from the committee expressing appreciation of the assistance given by the Branch and the office staff over a period of fifteen months, when the committee was accommodated at B.M.A. House.

Medical Equipment Control Committee.—The Council has cooperated with this committee in circularizing members of the Branch concerning various drugs and instruments affected by the war position. Members were also asked to make the fullest use of the Emergency Formulary of Australia with the object of preserving the strictest economy in drugs.

Civil Defence Organization.—Air-raid precaution equipment (steel helmets, respirators and arm bands) for the medical profession in the metropolitan area has been distributed to doctors from B.M.A. House by Mr. F. K. Davis, acting manager of the British Medical Agency.

Action has been taken by a special committee of the Council in connexion with the equipment of first-aid posts and the provision of hospital facilities for civilian casualties during an air raid. Also in regard to identification of doctors' motor cars to enable medical men to proceed on their way without restriction.

A.A.M.C. Medical Officers.—The military authorities have been approached in regard to the following:

Rate of pay to medical officers serving on military boards. Representation was made to the Minister for the Army protesting against the reduction in the rate of pay of medical officers serving on military medical boards. A reply was received to the effect that payment in accordance with rank is an established army policy and it is not considered that circumstances warrant any deviation from such policy in the case of medical officers.

The attention of the Deputy Director of Medical Services (Queensland) was drawn to the anomaly of calling up senior members of the profession for duty as consultants and allotting them the junior rank of captain. The Council considers this is contrary to the welfare of the patients and also to the dignity of the profession. There has not been sufficient time to receive a reply.

Volunteer Defence Corps: Medical Examinations.—A statement was received to the effect that provision is made for the payment for examinations, or volunteers may be examined by medical boards.

Medical Examinations of Recruits for Bodies Auxiliary to the Armed Forces.—The opinion has been expressed by the Federal Council that the examination of recruits for such bodies as the Women's Land Army should be carried out by medical officers employed by the Commonwealth Government departments.

Medical Service to Evacuees (Persons Evacuated from Vulnerable Areas).—No specific arrangement has been made in this State for a medical service to evacuees, and the opinion has been expressed by the Council that the medical care of the sick public, including evacuees, is the responsibility of the hospital board in each area. This does not exclude ordinary private practice.

Rationing of Doctors' Professional Clothing.—As a result of representations made to the Deputy Director of Rationing, advice has been received that in future certification by the Queensland Medical Board will be accepted in connexion with applications for special coupons issued to doctors for professional clothing.

Priority of Employees of Medical Practitioners.—Under National Security Regulations medical practitioners are rated at a high priority in this regard, but even with this privilege those who are left to bear the burden of private practice are finding great difficulty in carrying on without the necessary assistance, particularly domestic help, which is practically unprocurable and which is essential in the home of a busy general practitioner. It is felt that some definite action will have to be taken by the Manpower Authorities where necessary to enable doctors to provide the public with adequate medical service.

Motor Car Tires and Spare Parts.—The medical profession has been granted high priority in connexion with the supply of motor car tires and spare parts, and the British Medical Agency of Queensland is in a position to assist members in obtaining necessary requirements.

A General Medical Service for Australia.

This question is still under consideration, but it is not likely that any immediate action will be taken in view of an assurance received by the Federal Council of the British Medical Association from the Federal Minister for Health (the Honourable E. J. Holloway) that the scheme will not be introduced until after the war.

The close attention of the Branch Council is being given to the matter.

Conference of Country Members.

This year, on account of the war, it was decided to abandon the annual conference of country members, which is usually held in June.

Petrol Rationing.

A great deal of work has been done by the subcommittee appointed by the Council to deal with the question of petrol rationing on behalf of members and to act as a liaison between them and the Liquid Fuel Control Board. Mr. F. K. Davis, the acting manager of the British Medical Agency of Queensland, who is honorary secretary of the subcommittee, has been untiring in his efforts to assist medical men in this regard. The medical personnel of the subcommittee is as follows: Dr. L. P. Winterbotham (chairman), Dr. A. G. Anderson and Dr. Alec. Paterson.

It is to the advantage of members to cooperate with the subcommittee to the fullest extent possible.

Affiliated Local Associations.

Downs and South Western Medical Association.

Meetings.—The local association has continued to hold meetings at intervals during the year just ended. These were held in November, 1941, January, March, May and September, 1942. In June a combined meeting with the local Dental Association was held. Meetings of the executive were held in November (two), May and August. The annual meeting was held in September.

Membership.—The membership has dropped. Further members on full-time military service are Dr. A. S. Furness, Dr. R. J. H. Spark, Dr. Graham Wilson and Dr. C. R. Morton, of Toowoomba, and Dr. R. C. Dent, of Warwick.

Acknowledgements.—It is a pleasure to make our customary acknowledgements to visiting lecturers and to the Queensland Post-Graduate Committee for services in connection with our meetings. Our thanks are also due to Dr. Price and the Toowoomba Hospitals Board for the use of rooms for our meetings; also to Colonel Fowler for the invitations to meetings at the 117th Australian General Hospital.

G. V. HICKEY,
Acting Honorary Secretary.

Rockhampton Local Medical Association.

The following is the annual report of the local association for the year 1941-1942.

Membership and Office Bearers.—Dr. N. C. Talbot, Dr. Trevor Parry, Dr. W. E. Hasker and Dr. D. B. Walker are on full-time military duty with the military forces. It is gratifying to hear that Dr. Parry has been mentioned in despatches for his work in the Middle East. Of the remaining doctors in Rockhampton, Dr. F. C. Wooster was appointed President, and Dr. Paul Voss, Honorary Secretary. The other members are Dr. C. N. Matheson, Dr. J. Bruce Gordon, Dr. J. C. Ross, Dr. V. T. J. Lynch, Dr. R. Palmerston Rundle, Dr. Adah Stuart, Dr. Doris Skyring, Dr. Ruby Beveridge.

Negotiations with the lodges in this area during the last year have resulted in an amicable agreement being reached, that the lodge capitation fee for this district shall be the same as that prevailing in Brisbane, such fee to vary with the nominal wage index figure as fixed by the Government Statistician.

PAUL E. VOSS,
Honorary Secretary.

Maryborough Local Medical Association.

The following is a list of members of the local association: Dr. J. H. Bendeich, Dr. R. A. Baker, Dr. K. Hooper, Dr. Nettie Reid, Dr. Heather Kilgour, Dr. Egmont Theile.

No meetings of the local association have been held during the year.

EGMONT THEILE,
Honorary Secretary.

Queensland Post-Graduate Committee.

Annual Report, 1941-1942.

Personnel: Chairman, Dr. S. F. McDonald; Vice-Chairman, Dr. A. V. Meehan; Honorary Secretary and Treasurer, Dr. Alec. E. Paterson; Dr. Alex. Murphy, Dr. E. S. Meyers, Dr. N. W. Markwell, Dr. Alan E. Lee, Dr. P. A. Earnshaw, Dr. J. R. S. Lahz, Dr. L. B. Elwell, Dr. John Lynch, Dr. O. S. Hirschfeld, Dr. E. O. Marks, Dr. R. B. Charlton, Dr. J. Lloyd Simmonds, Professor J. V. Duhig, Professor G. Shedden Adam, Professor D. H. K. Lee, Professor H. J. Wilkinson, Colonel N. C. Talbot.

At the last annual meeting it was decided to coopt the Deputy Director of Medical Services, Headquarters, Queensland Line of Communication Area, Colonel N. C. Talbot, to the committee with a view to providing closer association between the Post-Graduate Committee and the defence medical officers.

Dr. J. R. S. Lahz and Dr. J. A. Lynch applied for leave of absence in February and May respectively, as they were both on full-time military duty. Dr. N. W. Markwell is also on leave of absence owing to military duties.

Meetings.—Seven meetings of the committee were held during the year.

Week-End Practical Revision Course.—A week-end practical revision course was held on November 7, 8 and 9, 1941, at which the average attendance at each session was 32. A total of thirty-six members joined the course, of whom thirteen were country members and four were medical officers from the Royal Australian Air Force. No subscription was charged for this course.

Annual Post-Graduate Course.—No annual course was held this year, but a week-end course was arranged for June 5, 6 and 7. Clinical demonstrations formed the main part of the programme and a lecture was delivered by a member of the United States Army Medical Corps. An invitation was extended to Army and Air Force medical officers. A letter of appreciation was received from Brigadier W. W. S. Johnston, D.S.O., M.C., A.A.M.C., Deputy Director of Medical Services, First Australian Corps, on behalf of the medical officers of the army.

Lectures to Country Centres.—As usual, arrangements were made for lecturers to visit the Downs and South Western Medical Association, Toowoomba. The North Coast and South Burnett Local Medical Associations were communicated with regarding a series of lectures for the members of these centres. A reply was received from Nambour stating that they would welcome such a scheme, but Kingaroy members were not in favour as their medical association is at present *"in extremis"*.

Finance.—The financial statement for the year ended June 30, 1942, shows a credit balance of £58 19s. 5d. During the year an amount of £150 was invested in the Commonwealth War Loan.

The Joseph Bancroft Memorial Lecture.

Dr. F. M. Burnet, of Melbourne, delivered the Joseph Bancroft Memorial Lecture for 1942 in the lecture hall of the Medical School on Friday, June 5. The subject of the lecture was "The Story of Rickettsial Disease in Australia".

There was an audience of ninety members and visitors, included amongst the latter being medical officers of the United States Army.

A vote of thanks to the lecturer was moved by Dr. E. H. Derrick, seconded by Dr. Alan E. Lee, and carried by acclamation.

At the conclusion of the lecture, the Joseph Bancroft Memorial Medal was presented by the President of the Branch to Dr. Burnet.

Jackson Lecture.

On September 4, 1942, the Jackson Lecture was delivered by Professor John Bostock in the lecture hall of the Medical School on the subject of "The Place of History in War and Post-War Problems".

British Medical Agency of Queensland Proprietary Limited and Queensland Medical Finance Proprietary Limited.

The activities of the British Medical Agency of Queensland have been greatly restricted owing to war conditions and the control of the movements of medical practitioners under National Security Regulations.

The acting manager of the agency, Mr. F. K. Davis, has rendered assistance to members during the year in very many ways, whenever called upon. A great deal of work has been entailed in connexion with petrol rationing and other war emergency matters.

The functioning of the Finance Company has been suspended for the duration of the war, but it is hoped, on the cessation of hostilities, that it will resume its useful service to members of the profession.

Federal Council.

Only one meeting of the Federal Council, which took place on September 25 in Melbourne, was held this year. The Branch was represented by Dr. T. A. Price and Dr. Alan E. Lee, the latter taking the place of Dr. D. Gifford Croll, who was unable to attend.

A report of the proceedings of the meeting was published in THE MEDICAL JOURNAL OF AUSTRALIA of November 14, 1942. As many important matters were considered at the meeting, members are advised to study the report.

The Australasian Medical Publishing Company Limited: "The Medical Journal of Australia".

Advice has been received that a rebate of 10s. will be allowed for the year 1943 for each member who has totally relinquished civil practice as at December 31, 1942, for full-time service with His Majesty's Forces. Subscriptions payable to the Branch by these members have been reduced accordingly.

A letter of thanks was sent to the directors of the company for this further generous gesture.

The University of Queensland Medical School.

Dean of the Faculty of Medicine.—Dr. E. S. Meyers was congratulated by the Council upon his appointment as Dean of the Faculty of Medicine of the University of Queensland.

Post-Graduate Medical Education Committee.—The Senate has approved of the appointment of Dr. S. F. McDonald, Dr. Alan E. Lee and Dr. Alec. Paterson, who were nominated by the Queensland Branch of the British Medical Association as its representatives on the Post-Graduate Medical Education Committee. This committee has not yet commenced to function.

British Medical Association (Queensland Branch) Queensland Medical Students' Loan Fund.—A new constitution has been drawn up which includes the following:

> *Purpose of the Fund.*—1. To provide limited financial assistance to impecunious and deserving undergraduates to enable them to complete their course.
>
> 2. To provide a fund to receive contributions from undergraduates and graduates of medicine of the University of Queensland and from other medical graduates generally practising in Queensland and other benefactors who wish to assist in the purpose of the fund.
>
> *Control of the Fund.*—The control of the fund shall be vested in the Council of the Queensland Branch of the British Medical Association, hereinafter briefly referred to as the Council, who shall appoint a committee whose duties shall be as hereinafter set out.

The personnel of the present committee is as follows: Dr. C. A. Thelander (chairman), Professor H. J. Wilkinson, Dr. Alex. Murphy and Dr. E. S. Meyers.

Provision is made for the representation of medical students on the committee of administration by "one associate (that is, undergraduate) member of the British Medical Association who shall be nominated annually by the Queensland Medical Students' Association as their representative".

The Queensland Medical Students' Association.—In compliance with a request copies of the *British Medical Journal* and THE MEDICAL JOURNAL OF AUSTRALIA, which are made available by members of the Branch, are supplied to this association for the use of senior medical students in their common room.

Harold Plant Memorial Prize.—In accordance with the conditions of the awarding of the Harold Plant Memorial Prize, the President of the Branch presented a cheque to Dr. W. S. Georgeson, the winner of the prize for 1942.

Eustace Russell Memorial Prize.—The 1942 prize was awarded to Dr. Evan R. W. Thomson, M.B., B.S.

William Nathaniel Robertson Medal.—Dr. Evan R. W. Thomson was also the winner of the medal for 1942.

The Medical Board of Queensland.

During the year a list of specialists, Queensland, for the year 1942, published in pursuance of the provisions of *The Medical Acts*, 1939 to 1940, was issued by the Medical Board of Queensland. This entailed a great deal of work upon the members of the Board.

"The Medical Acts, 1939 to 1940."

In view of appeals before the Medical Assessment Tribunal concerning applications for registration as specialists, a letter was sent to the Minister for Health and Home Affairs, the Honourable E. M. Hanlon, M.L.A., in September last, drawing attention to our previous protest (when the new bill to amend the *Medical Act* was under consideration) concerning the cost of litigation being met out of the registration fees paid by the medical profession. A reply was received from the Minister stating that the matter will receive consideration when the *Medical Acts* are under review. It was also mentioned that it is not proposed to introduce any amendments to the *Medical Acts* during the current session of Parliament.

Red Cross Society Appeal.

The appeal made to members of the Branch last Christmas for the Red Cross Society resulted in an amount of £321 16s. 6d. being subscribed.

Social.

No social activities took place during the year in connexion with the Branch.

A.A.M.C. Medical Officers.—A committee has been appointed to arrange hospitality for visiting A.A.M.C. medical officers from other States during their period of leave. The personnel of the committee is as follows: Dr. Alan E. Lee, Dr. S. F. McDonald, Dr. J. G. Wagner.

The visiting medical officers have also been invited to attend all scientific meetings and post-graduate courses which have been held during the year.

Medical Officers of the United States of America (Armed Services).

Invitations to all scientific meetings of the Branch have been extended to medical officers of the Armed Services of the United States of America stationed in Australia and they have also been offered the facilities of the Branch and the use of the library.

These medical officers have been invited to attend post-graduate courses arranged by the Queensland Post-Graduate Committee, and during a week-end course held early in November several of them assisted in the programme.

Finance.

The year's operations have resulted in a small credit balance.

It seems likely that in the near future the Branch will incur considerable expense for organization purposes, and it is imperative that members should recognize that the Branch needs to be financially strong to enable the Council to carry out its obligations to the profession.

British Medical Association Building Fund.—The loan from members of the Branch in connexion with the Building Fund has been repaid to them out of an interest free loan to the Branch from the Queensland Medical Land Investment Company, Limited, from funds made available by the completion of the sale of the Adelaide Street property.

Conclusion.

It will be seen from the report that considerable activity has taken place during the year.

All this activity has resulted in considerable increase in duties for Mrs. Spooner and the office staff. This work has been undertaken as always with loyalty and efficiency.

During the year Miss Nancy Heaslop, who was a member of the staff for nine years, left to join the W.A.A.A.F.'s, with whom she is now serving. It was with regret that the Council accepted her resignation.

It is felt by the Council that the immediate future may produce changes in medical practice. It is therefore of

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

(INCORPORATED.)

Balance Sheet as at November 15, 1942.

LIABILITIES.	£ s. d.	£ s. d.
Fixed Liabilities—		
Loan from Queensland Medical Land Investment Co. Limited		4,650 0 0
Current Liabilities—		
Subscriptions for Remittance to—		
British Medical Association London	40 5 5	
Australasian Medical Publishing Company Limited, Sydney	37 17 6	
		78 2 11
Association Funds—		
Accumulation Account	3,462 9 7	
Sinking Fund	355 2 9	
Reserve for Dinners, Entertainments, etc.	31 17 2	
		3,849 9 6
		£8,577 12 5

ASSETS.	£ s. d.	£ s. d.
Fixed Assets, at cost, less depreciation—		
Land and Buildings — "B.M.A. House"	2,583 0 0	
Library	150 0 0	
Typewriters, Book-cases, Balopticon and Furniture	103 15 0	
Queensland Medical Land Investment Co. Ltd.—5,950 shares of £1 each paid to 10s. each—at cost	2,975 0 0	
British Medical Agency of Queensland Proprietary Limited—257 shares of £1 each fully paid—at cost	257 0 0	
Australasian Medical Publishing Company Limited—5% Debentures—at cost	55 0 0	
		6,123 15 0
Current Assets—		
Sundry Debtors	442 0 0	
Electric Light Deposit	6 0 0	
English, Scottish and Australian Bank Ltd. — Credit Balance, Current Account	1,639 10 6	
Cash in hand	11 4 2	
		2,098 14 8
Sinking Fund Investments—		
Australian Consolidated Inscribed Stock: £280, 3½%, maturing 1951—at cost	278 3 3	
Commonwealth Savings Bank, Brisbane, Credit Balance	76 19 6	
		355 2 9
		£8,577 12 5

We have compared the above Balance Sheet with the Books, Accounts and Vouchers of the Queensland Branch of the British Medical Association (Incorporated), and have obtained all the information and explanations we have required.

In our opinion, the Balance Sheet is properly drawn up to exhibit a true and correct view of the state of the Association's affairs as at November 15, 1942, according to the best of our information and the explanations given us, and as shown by the books of the Association.

R. G. GROOM & Co.,
Chartered Accountants (Aust.),
Auditors.

Brisbane, November 16, 1942.

(Sgd.) J. G. WAGNER,
Hon. Treasurer.

extreme importance that all members of the medical profession should display interest in the future of medicine, and endeavour to influence the course of events so that the progress of medicine shall be on sound basic principles, and not in accordance with political expediency.

(Sgd.) F. W. R. LUKIN, President.

FINANCIAL STATEMENTS.

The Honorary Treasurer presented the financial statements, which were taken as read on the motion of Dr. J. G. Avery, seconded by Dr. D. Gifford Croll; their adoption was moved by Dr. Alec. E. Patterson, seconded by Dr. J. G. Avery.

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

(INCORPORATED.)

Revenue Account for Twelve Months ended November 15, 1942.

EXPENDITURE. Nov. 15, 1942.	£ s. d.	£ s. d.
To Branch Expenses	602 12 9	
„ Contribution to Federal Council for 1942 Expenses	160 16 6	
„ Library Expenditure	35 8 5	
„ Allowances to Delegates attending Federal Council Meetings	29 8 6	
„ Depreciation of Office Equipment	10 10 0	
		838 16 2
„ Expenses B.M.A. House—		
Rates, Land Tax, Insurance, Repairs and Sundries	155 11 10	
Interest on Loans from Members	23 10 0	
Cleaning	31 0 0	
Depreciation, Building	57 0 0	
	317 1 10	
Less Rents received	38 0 9	
		279 1 1
„ Accumulation Account—		
Profit for year transferred		554 5 10
		£1,672 3 1

INCOME. Nov. 15, 1942.	£ s. d.	£ s. d.
By Branch and Organization Fund Subscriptions		1,666 10 3
„ Australasian Medical Publishing Company Limited—		
Interest on Debentures	2 15 0	
„ Sale of Nutrition Pamphlets	2 17 10	
		5 12 10
		£1,672 3 1

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

(INCORPORATED.)

GENERAL FUND.

Statement of Receipts and Payments for Twelve Months ended November 15, 1942.

RECEIPTS.	£ s. d.	£ s. d.
To Funds at November 16, 1941—		
E.S. & A. Bank Ltd.—Current Account	2,740 12 6	
Cash in Hand	11 4	
		2,741 3 10
„ Subscriptions—		
For remittance to British Medical Association, London	676 9 4	
For remittance to THE MEDICAL JOURNAL OF AUSTRALIA, Sydney	487 5 0	
Queensland Branch Subscriptions	856 19 9	
Organization Fund, Queensland Branch	809 10 6	
		2,830 4 7
„ General—		
Rent:		
Basement and garage £26 10 0		
Australasian Trained Nurses' Association 3 0 0		
Lecture Room 10 9		
Medical Defence Society 5 0 0		
	35 0 9	
Sale of Nutrition Pamphlets	2 17 10	
Australasian Medical Publishing Company Limited—		
Interest on Debenture	2 15 0	
		40 13 7
		£5,612 2 0

PAYMENTS.	£ s. d.	£ s. d.
By Amounts remitted on account of Subscriptions Collected, to—		
British Medical Association, London	709 10 4	
Australasian Medical Publishing Company Limited, Sydney	499 0 6	
		1,208 10 10
„ General—		
Payments on account of Building Fund—		
Overdraft at Bank	1,662 3 4	
Dr. J. Ross—Loan and Interest	102 13 9	
Rates to December 31, 1942	64 8 4	
	1,829 5 5	
Contribution to Federal Council 1942 Expenses	160 16 6	
Allowances to Delegates attending Federal Council Meetings	29 8 6	
Library Expenditure	35 8 5	
		2,054 18 10
„ Branch Expenses—		
Salaries, Audit and Honoraria	424 16 10	
Printing and Stationery	33 17 9	
Postages and Duty Stamps	56 1 0	
Telephone Rental and Calls	29 17 4	
Electric Light	10 8 3	
Bank Charges, Meeting Expenses and Sundries	19 6 11	
Legal Expenses	21 10 6	
A.R.P. Expenses	5 2 8	
	601 1 3	
Building Repairs and Maintenance	6 16 4	
Cleaning	81 0 0	
Insurance	9 0 1	
		697 17 8
„ Funds at November 15, 1942—		
E.S. & A. Bank Ltd.—Brisbane	1,639 10 6	
Cash in hand	11 4 2	
		1,650 14 8
		£5,612 2 0

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

(INCORPORATED.)

BUILDING FUND.

Statement of Receipts and Payments for Period from November 16, 1941, to March 31, 1942.

RECEIPTS.	£	s.	d.
To Rent from B.M.A. House, Wickham Terrace	3	0	0
„ Loan from Queensland Medical Land Investment Company Limited	3,000	0	0
„ General Fund—Payment of Overdraft	1,662	3	4
	£4,665	3	4

PAYMENTS.	£	s.	d.	£	s.	d.
By English, Scottish and Australian Bank Ltd., Brisbane—Overdraft at November 16, 1941				1,697	9	9
„ Repayments of Loans				2,797	10	0
„ Rates, Land Tax and Insurance—B.M.A. House, Wickham Terrace	75	7	1			
„ Interest on Loans from Members	93	5	0			
„ Bank Charges	1	11	6			
				170	3	7
				£4,665	3	4

ELECTION OF OFFICE BEARERS.

The President announced the result of the election of office bearers and members of the Council.

President: Dr. Alan E. Lee.
President-Elect: Dr. L. P. Winterbotham.
Past President: Dr. F. W. R. Lukin.
Honorary Secretary: Dr. W. H. Steel.
Councillors: Dr. Felix Arden, Dr. J. G. Avery, Dr. R. B. Charlton, Dr. D. Gifford Croll, Dr. Milton Geaney, Dr. Basil L. Hart, Dr. H. W. Horn, Dr. S. F. McDonald, Dr. Alec. E. Paterson, Dr. Mervyn S. Patterson, Dr. T. A. Price, Dr. Lloyd Simmonds, Dr. J. G. Wagner, Dr. C. E. Wassell.

ELECTION OF AUDITORS.

On the motion of Dr. Felix Arden, seconded by Dr. J. G. Avery, Roy G. Groom and Company were appointed auditors.

ETHICS COMMITTEE.

On the motion of Dr. L. P. Winterbotham, seconded by Dr. D. Gifford Croll, Dr. A. H. Marks, Dr. G. P. Dixon, Dr. Gavin Cameron, Dr. W. Graham Sutton and Dr. J. Jarvis Nye were appointed as members of the Ethics Committee.

OFFICE STAFF.

Dr. F. W. R. Lukin proposed a vote of thanks to the office staff for their work during the year. This was carried by acclamation.

INDUCTION OF PRESIDENT.

Dr. Lukin then inducted Dr. Alan E. Lee to the chair.

PRESIDENT'S ADDRESS.

Dr. Alan E. Lee read his address (see page 45).

VOTE OF THANKS.

Dr. Lee proposed a vote of thanks to Dr. Lukin and the Council for their work during the year. He referred particularly to the work of Dr. Lukin, who, at a particularly busy time in his practice, had attended all Branch and Council meetings with unfailing good humour. Dr. Lee was sure that in years to come Dr. Lukin would rank as one of the great Presidents of the Branch.

Dr. L. J. J. Nye seconded the vote of thanks, which was supported by Dr. R. B. Charlton and carried by acclamation.

SCIENTIFIC.

A MEETING of the New South Wales Branch of the British Medical Association was held on July 23, 1942, at the Royal Hospital for Women, Sydney. The meeting took the form of a series of clinical demonstrations by the members of the honorary medical staff of the hospital.

X-Ray Methods in Obstetrics.

DR. E. W. FRECKER gave a demonstration of X-ray methods used in the measurement of the pelvis and the fœtal head. He said that the problem of labour was largely a mechanical one, involving the transit of the fœtus through the maternal passages. There could therefore be no subject of greater interest to the obstetrician than the absolute and relative sizes of fœtus and pelvis, especially if the quantitative findings were accompanied by a statement of the shape and spatial relations of these two components. In so far as labour was a mechanical problem, such quantitative data constituted fundamental circumstantial information necessary for the provident and safe conduct of labour.

Without the use of X-ray methods, the clinician resorted to less exact means to ascertain these necessary data. Facts concerning the fœtus, its position, its presentation and its lie, were deduced by palpation and auscultation through the abdominal and uterine walls and by vaginal examination. Facts concerning the pelvis were obtained by measurement of the external diameters, by palpation *per vaginam*, by the history of previous labours, and lastly, by the expedient of pressing the fœtal head into the pelvic brim to ascertain whether any gross disproportion existed.

Dr. Frecker said that such manœuvres were of value and often were the only methods available; but he pointed out the increased precision that could be secured by the additional use of the radiographic method in the pre-natal period. When a fractured limb was examined, the eyes and hands with external measurement gave valuable information; but if to such clinical gains a properly taken X-ray picture was added, they then had a fundamental addition to their knowledge of the injury which far exceeded in value anything they could otherwise obtain. Similarly, the clinical examination of the lungs threw some light on the condition within; but an added X-ray picture gave circumstantial and exact anatomical detail almost substituting direct vision for intellectual deduction from obscure physical signs.

In Dr. Frecker's opinion the position was precisely the same in obstetrics. He thought that they could be content to obtain a general clinical impression, the correctness of which certainly varied with the talents and experience of the clinician, or they could obtain a view of the pelvis and the fœtus which was anatomically accurate and conclusively definite. From the quantitative aspect they could, by the use of X rays, obtain dimensions of the pelvic diameter correct to two or three millimetres. They could obtain a correct picture of its shape as well as its size, and finally, they could also obtain a reasonable estimate of the volumetric relations of the head to the pelvis. From a consideration of shape, size, position and relations, the plan of labour could be marked out, and the obstetrician, having control of the fundamental facts, became a foreseeing intelligence rather than a guiding hand.

Dr. Frecker pointed out that the complete radiological examination was in a general sense incomplete; it concerned only the skeletal parts and took but little account of the soft tissue abnormalities. As was well known, an ovarian cyst, a fibroid tumour, a fœtal tumour or even a rigid lower uterine segment could materially affect the course of labour or even bring it to a standstill. The consideration of labour involved three factors: the passenger, the passage and the powers. The two former were considered by the radiologist, at least so far as concerned their skeletal parts; but the factors influencing the powers were quite beyond his ken. The radiologist therefore, from the most extensive X-ray investigation and the most accurate pelvic measurements, should not be expected to predict whether the mother would or would not deliver the child. In this connexion, as elsewhere, he was the hand-maiden to the clinician, furnishing him with data which attained their full function only when taken in hand and used in the light of all the other information available. His X-ray findings were a

warning or a reassurance, but never a prophecy, because his method of examination from its limited viewpoint excluded many of the essential factors. That point required to be laboured to prevent improper expectations. The data, though themselves incomplete, if properly given, constituted a fairly complete analysis of the pelvis and fœtus, giving the obstetrician the "physical geography" of labour and enabling him to proceed with scientific prevision in his management. The obligation lay on the obstetrician to develop and use these new methods, for without his aid and interest they remained buried talents which the radiologist could not employ unaided. Dr. Frecker said that it was his firm opinion that the metric X-ray film would be as necessary to the obstetrician of the future as the fracture film was to the surgeon, or the chest film to the physician. To develop the usefulness of the method needed the interest of the obstetrician. In other words, if the obstetrician desired adequate X-ray service for his work, he must assist in educating the radiologist as to his needs and give him such facilities as would enable him to acquire a fundamental knowledge of obstetric problems. Dr. Frecker affirmed that the quantitative X-ray measurement of the pelvis was as exact as it could humanly be made, and that the estimation of the relative size of the fœtal head to the pelvis was highly valuable, though perhaps a little less certain than the measurement of pelvic diameters. The obvious scope for improvement lay in the qualitative analysis of the pelvic shape and its influence on the course of labour, and it was in this connexion that obstetrical cooperation was needed more than elsewhere.

Dr. Frecker then demonstrated the films and apparatus employed by the radiologist in the Thom method of pelvimetry and the Ball method of pelvicephalimetry.

MEDICAL WAR RELIEF FUND.

THE following letter has been received by the General Secretary of the Federal Council of the British Medical Association in Australia from Dr. G. C. Anderson, C.B.E., London.

British Medical Association House,
Tavistock Square,
London, W.C.1,
21st October, 1942.

My dear Hunter,

I have received your letter of 22nd July and the final contribution of £A494 16s. 8d. from the B.M.A. in Australia to the Medical War Relief Fund. I enclose the official receipt.

It is difficult to express adequately our appreciation of the extreme generosity of our Australian colleagues. The total sum that they have subscribed is a magnificent contribution to the Fund and we are deeply grateful for it.

I am glad to say that during the past year, largely owing to the diminution in the severity of air attacks, there has been a considerable reduction in the number of appeals for assistance and we now have a very substantial balance in hand. We hope to publish shortly in the Journal a further statement for the information of subscribers, including additional illustrative case summaries.

Now that the war has come so near to your country we appreciate all the more the continued interest of our Australian friends in our Fund. You have done far more for us than we had any right to expect. Please convey to the Federal Council, and to all who have given so generously, our most sincere and grateful thanks.

Kindest regards and all good wishes,

Yours sincerely,
(Signed) G. C. ANDERSON,
Honorary Treasurer.

Dr. J. G. Hunter,
General Secretary.
Federal Council of the B.M.A. in Australia.

Public Health.

PARLIAMENTARY JOINT COMMITTEE ON SOCIAL SECURITY.

THE Parliamentary Joint Committee on Social Security was appointed "to inquire into and from time to time report upon ways and means of improving social and living conditions of the people of Australia and of rectifying anomalies in existing legislation". The personnel of the committee is as follows: Mr. H. C. Barnard (Chairman), Senator Cooper (Deputy Chairman), Senator Arnold, Mr. Maurice Blackburn, Colonel R. S. Ryan and the Honourable J. A. Perkins.

Evidence taken in Melbourne has been published in previous issues.

DR. JEAN MACNAMARA, being sworn, informed the committee that she proposed to confine her evidence to the problem of the cripple and the potential cripple.

Some children were born handicapped on account of the difficulties of their mothers during pregnancy or by injury at birth, and any plan which provided for the best possible ante-natal and natal care would reduce the number of children commencing life with spastic paralysis, which was the cause of crippling in a small but economically important group. She had noted that the scheme proposed by the Federal Council of the British Medical Association stressed the need for continuity of medical care, but how that plan was to be implemented was not within the field of her discussion. It did not appear, however, that any of the plans for changes in medical practice, which had been published, offered anything which would reduce crippledom. To arrange for the provision of excellent doctors and hospitals for the care of, say, tuberculosis, was wrong. The disease should be prevented, as the child with bone or joint tuberculosis acquired its disease from infected cow's milk or a tuberculous adult, and any system which allowed an infected adult to infect a child did nothing for the child. More than medical care was needed to combat tuberculosis—the economic factor was just as important. Although infected milk was not so important a cause of tuberculosis in Australia as in Scotland, it was responsible for some cases, and that should not be so. Over ten years earlier Toronto had enforced universal pasteurization of its milk supply and so abolished the trouble at its source.

In Victoria, poliomyelitis was the largest single cause of crippling, but again the plans seemed to offer little help to the crippled child, except that in the National Health and Medical Research Council scheme, orthopædists and specialists were available.

The community had progressed beyond the stage where the cripple was the object of fun or charity; he should be a useful member of society and a great deal of cooperation was needed to accomplish that aim.

In the case of sufferers from poliomyelitis specially trained doctors, nurses, physiotherapists, splint-makers and teachers were needed, and later, training for and placing in employment.

In 1937 Victoria had the worst epidemic of poliomyelitis in its history, and a system for after-care had been established under State control with more elaborate arrangements than had ever before operated, and paid orthopædists and physiotherapeutists had been employed.

One striking fact had, however, emerged from the 1937 epidemic, and that was that, whereas in earlier epidemics parents of affected children had paid for necessary splints and had received very little governmental help, they had been most cooperative and results had been good, in the 1937 epidemic mothers expected the Government to do everything for them and the results were not so good.

Dr. Macnamara did not think that very much could be done during the war except to hold together the good work of two decades, as nearly all the orthopædists, physiotherapeutists, splint-makers and boot-makers were on military duty, and the almoners of the Victorian Society for Crippled Children were short of petrol. The society had done a great deal for the rehabilitation of cripples and should be able to help those crippled on war service, but it was hoped that in any post-war plan to assist handicapped soldiers, those unable to serve through no fault of their own would not be omitted.

Replying to Colonel Ryan, Dr. Macnamara said it was difficult to give exact figures of the proportion of cripples in the population as the number varied with the incidence of poliomyelitis and the efficiency of after-care. In the 1937 epidemic in Victoria there were 2,000 cases and in the previous decade 1,000. Of those 20% cleared up quickly, 50% more slowly but with little crippling, and 20% to 30% of patients were crippled to a greater or less extent and needed help.

In the United States of America there was a Union of Cripples with over 1,000,000 members, and one of its activities was to examine plans of public buildings to see that they were designed to meet the needs of the disabled.

Poliomyelitis was responsible for about 50% of cripples in Victoria, the other major causes being tuberculosis, birth injuries, rickets, congenital abnormalities, rheumatoid arthritis and accidents.

If a cripple remained a cripple from sixteen to sixty-six years of age, he cost the community about £2,000 in invalid pension payments, so it was obvious that on economic grounds alone the welfare of cripples was important.

Dr. Macnamara stressed her opinion that if people had to struggle for something, they valued what they had struggled for, an attitude exemplified in the care and maintenance of splints paid for by parents, and she feared that the same psychology would temper the public reaction to a free medical service.

Replying to Senator Cooper, Dr. Macnamara said there was a tendency for some parents to allow a child to remain a cripple and draw an invalid pension; in fact she regarded the invalid pension system as a factory for cripples; but propaganda by the Victorian Society for Crippled Children was overcoming that attitude and, in addition, the rousing of ambition in the children themselves did a great deal to combat it. She contrasted the position in Victoria with that in the United States of America, where there was no provision for invalid pensions, with the result that the family as a unit did all it could to train a crippled child, and where employers accepted a percentage of cripples in their factories.

Birth injuries and congenital disabilities were not limited to any one stratum of society and much could be done to lessen such causes of crippling by any plan which provided for good ante-natal care. Propaganda could be used much more in Australia and had been a feature of health education in Toronto.

Replying to Senator Arnold, Dr. Macnamara said that baby health centres had started on a small scale in Victoria, but from the beginning mothers welcomed them, and their growth in what was a conservative community showed their value. Factors which "sold" the centres to mothers were their architectural attractiveness, baby-scales, and the distribution of patterns for clothing. The idea that nurses at centres did not know anything about babies because they had none of their own, was the attitude of jealous mothers-in-law.

Extension of the work of centres to care for older children with the establishment of kindergartens and mothers' clubs, where mothers could be educated in the proper spending of child endowment, were avenues which could be developed.

She thought it important to remove a child at birth from the care of a tuberculous mother and considered that the X-ray examination of those between fifteen and twenty-five years of age would be of value. If radiological facilities were to be readily available, it would also be worth while to examine with X rays all female children soon after birth to detect congenital dislocation of the hip, a method which had been adopted in Italy.

The Chairman thanked Dr. Macnamara for her evidence and assured her that the needs of cripples would not be overlooked in the recommendations of the committee.

MR. C. L. MCVILLY, Inspector of Charities and Secretary to the Charities Board of Victoria, being sworn, submitted a statement surveying the position of hospital accommodation in Victoria and demonstrating that the hospital system in that State was not organized in relation to the distribution of population.

He explained the policy of the Charities Board of Victoria in developing hospitals, especially in the country, where subsidized radiologists and/or pathologists were now employed in three base hospitals.

He felt that the honorary system of medical service should be abandoned, as it imposed unjust obligations on the medical profession and was foreign to the principles of social service. Plans for hospital services should be governed by the following principles: (i) Any scheme should provide services to all groups in the community. (ii) The services should be on a social and not a charitable basis. (iii) Hospitals (for acute, chronic and mental cases) and sanatoria should be planned on a regional basis and should provide for those desiring private accommodation. (iv) Local voluntary interest should be preserved. (v) Finance should be by taxation, compulsory contributory schemes, and patients' payments.

Proper health services were fundamental to the national well-being and should be conducive to the birth of good children, be capable of maintaining community health, and exclude unhealthy immigrants. Also, organizations—creches, clubs *et cetera*—should be developed to help mothers.

Replying to Mr. Perkins, Mr. McVilly said that, in general, the state of hospital buildings in Victoria was good, but the bed accommodation available was not in keeping with the demand.

In reply to Senator Arnold, Mr. McVilly said that the hospital bed rating in Victoria was about five beds per 1,000 of population, and the generally accepted minimum was 7 per 1,000. The shortage of beds was mainly in the metropolitan area and war conditions had held up the building programme of the Charities Board, which was planning for 400 additional beds in five new hospitals at a cost of £720 per bed. He felt it worried the average wage-earner to enter a hospital feeling he was receiving charity and honorary medical services. War conditions and the disinclination of the medical profession to extend honorary services had led to difficulties in staffing hospitals, especially the out-patient departments, and he considered that medical staffs should be paid.

Replying to Colonel Ryan, Mr. McVilly said that hospitals in Victoria were financed by Government grant of £440,000 *per annum* (43% of costs), contributions by patients (26% to 28%), donations (15%), and the balance from interest on investments of hospital funds. In recent years capital expenditure on hospitals had been financed by public appeals and Government subventions.

He was not prepared to say whether or not hospitals should be taken over by the Commonwealth, but any future scheme, whether Commonwealth or State, must be a coordinated one which should maintain local interest.

The general principles of the National Health and Medical Research Council proposals appeared to him to be sound, but the right of individuals to obtain private services should be preserved.

Very few of the military hospitals could be converted to civil use after the war.

Cooperative hospitals, such as bush nursing hospitals, catered mainly for their own members and those who could pay and not for all the people in their districts, and should be incorporated in any future general plan for the control of hospitals.

Only those institutions whose objects were charitable shared in the Government grant, and denominational hospitals of the "intermediate" type and cooperative hospitals were not subject to any central control, apart from their registration as private hospitals by the Department of Public Health under the provisions of the *Health Act*, which specified certain standards. At Wonthaggi the Government built a hospital and gave it to the miners to maintain, maintenance funds being obtained by deductions from wages, but about ten years ago it had become necessary to develop the hospital to serve the district and it was now a public hospital under the *Hospitals and Charities Act*, receiving a Government grant of about £1,700 *per annum*. The miners paid approximately 2s. 4d. per week and, in return for that contribution, were entitled to hospital service for themselves and their dependants and to contract medical and pharmaceutical services.

The Yallourn Hospital was not under the control of the Charities Board, but negotiations were proceeding to make it a general public hospital.

The provincial base hospitals were well staffed and well equipped and specialist services were available to patients.

The State Government had approved of a plan for the establishment of small units at base hospitals to care for patients suffering from advanced tuberculosis who had hitherto imposed a strain on the general hospitals.

The "private" hospital conducted as a business venture was being superseded by denominational and cooperative hospitals and, although they should be coordinated in any national scheme, he thought they should otherwise be left alone.

The present shortage of nurses was, he considered, largely attributable to unsatisfactory conditions and low wages.

Replying to Senator Arnold, Mr. McVilly said that out-patient departments were congested, the main reasons being the inability of those attending to afford private medical fees, the fact that some of the patients regarded "out-patients" as a club, and that honorary medical officers had so many calls on their time that they could not cope with the work. The remedies, he considered, were to conduct out-patient departments on an appointment system and to return as many as possible of the patients to private doctors.

Mr. McVilly informed Senator Cooper that he was of the opinion that if the Commonwealth Government assumed control of hospitals, it must be on a decentralized basis under a Department of Social Services.

DR. H. C. COLVILLE, being sworn, informed the committee that he was a general practitioner. He found it difficult to give an exact opinion, but felt that, in general, existing medical services were in many ways satisfactory, although they could be improved. He had studied the National Health and Medical Research Council proposals, which he regarded as revolutionary, and, if implemented, would result in an

upheaval of the existing system of medical practice, and was such an upheaval necessary or justified?

In reply to Mr. Barnard, Dr. Colville said that he had not had any experience of salaried medical services, but such services might be desirable in outlying districts.

He considered that the proposals of the Federal Council of the British Medical Association for a general medical service were an attempt to provide an efficient service for a section of the community below a fixed income limit, and that those proposals, in so far that they offered improved services to the poorer members of the population, might meet, in whole or in part, the needs of the people of Australia.

Like the majority of practitioners, he would not like a system of national health insurance to be introduced.

Dr. Colville emphasized his opinion that the introduction during the war of any new system of medical practice would be unfair to doctors and to members of the community on service, as both sections were entitled to a voice in the fashioning of future arrangements for medical care.

He could not imagine that any proposal that the Government should build up funds during the war, earmarked for expenditure on health services later, would be practicable in view of the necessity for diverting all possible resources for war purposes.

He considered that the existing system of hospital organization was almost on the point of breaking down, and that something would have to be done about it. There was no question that hospital accommodation in Victoria, both public and private, was inadequate, and it seemed to be nobody's business to see that the necessary accommodation was provided. He could not say whether the problem could be better dealt with by the Commonwealth, but from the practical point of view, action by State authorities was necessary, even if the Commonwealth provided the money.

Discussing group practice, Dr. Colville said that it was an excellent method, already working successfully in isolated instances, and from the patients' point of view it saved the necessity of travelling to obtain additional opinions. It was impossible now for an individual doctor to provide a complete medical service, and extension of the group practice system covering all specialties, without destroying the existing system of private practice, would be a good thing.

In reply to Mr. Perkins, Dr. Colville said that hospital buildings and equipment in Victoria were good, and that the older and less efficient private hospitals were going out of business.

Nursing was at present a serious problem, as the pool of nurses was inadequate to meet the needs of the civil community. Many nurses were in the Services, while others had sought other employment with better pay and conditions.

He considered that the demand for change in the medical system came largely from politicians, as he was not aware that those most intimately concerned, the public and the doctors, had expressed any considered opinion that any revolutionary change was needed.

The domiciliary treatment of the sick poor was admittedly inadequate. If they were sick enough to be admitted to public hospitals they got the best of treatment, but many suffering from chronic illnesses not warranting admission to hospital were "stranded" unless they belonged to a friendly society and could obtain the services of a lodge doctor.

Asked by Senator Arnold how the section of the people he had referred to as lacking medical care could be catered for, Dr. Colville said that some all-embracing scheme to cover them would be desirable, but the form of that scheme was a matter for discussion. It might be done by some form of insurance or by the employment of doctors by the Government. The group he referred to, many members of which were improvident and a charge on the community, imposed an unwarranted burden on the medical profession which often had to render necessary service on a purely compassionate basis, but by and large there were few instances in Melbourne of persons lacking the medical care they required.

The group systems of practice he had previously referred to were conducted as private enterprises, and practitioners could, if they desired, form their own groups.

The establishment of clinics with salaried medical officers could, he considered, be one phase of a Government-controlled scheme; in fact, it was the basis of the National Health and Medical Research Council proposals, but nothing of the sort should be introduced during the war except, perhaps, as an isolated activity designed to meet special needs.

Those planning any general change in the system of medical practice should seek the opinions of all concerned, the public and the doctors, including those on service, but he was sure that most doctors in the Services would prefer, on demobilization, to establish themselves in practice, and that they were not pining for a ready-made scheme to be prepared, into which they would be absorbed. He could see no justification for an unheaval of the existing system of medical practice unless the desire for change represented the wishes of the majority of the members of the community.

Views of doctors and the public could be obtained on the broad outlines of any plan, possibly by *questionnaire*, and he was sure that if the public was asked, "Do you value your right to choose your own doctor, or would you prefer to be a unit in some wholesale system?", the majority would prefer the present system to continue.

The breakdown in the hospital system, to which he had referred, was due to lack of accommodation, but the honorary system was far from satisfactory, and its days were numbered. All medical officers of public hospitals should, he considered, be paid for their services, and there was already a trend for that to be done, as many radiologists and pathologists were now on salaries. Honorary appointments were graded (clinical assistant, out-patient honorary, in-patient honorary *et cetera*) and promotion depended upon seniority, efficiency and the possession of special qualifications, promotions being made by committees of management, acting on the advice of the Advisory Board.

Replying to Senator Cooper, Dr. Colville said that the out-patient departments were overcrowded and the proportion of patients to each doctor was at present too high. The disability arose from war conditions because clinical assistants, who were mainly general practitioners, were so overworked that they could not attend the hospitals.

Many patients attending hospitals could be dealt with by private doctors, and, under present conditions, hospital managements were more discriminating and turned away, among others, lodge patients with disabilities which could be dealt with by their lodge doctors.

The friendly societies, however, required that candidates for membership be examined before acceptance, and the chronic invalid, who needed medical service, could not join a lodge.

He thought the nursing position would become worse, as under present conditions recruits to the nursing profession were not available, but he agreed that potential nurses would be attracted to a Commonwealth-wide scheme with uniformity of conditions and improved pay.

Replying to Colonel Ryan, Dr. Colville agreed that one class, the low wage earners, were badly served at present, and if he had the responsibility of planning for their needs he would, for those people, prefer a salaried medical service to a panel system.

He could envisage an extension of the hospital out-patient system with salaried medical officers making domiciliary visits, but such a system, unless protected by adequate assessment of patients and if abused as out-patient departments were at present abused, would be pernicious. He would not object to those really entitled being served in such a way, but they were a comparatively small group because of the generally high level of wages and it was his experience that those earning high wages who could afford private attention preferred it.

Correspondence.

THE FUTURE OF MEDICAL PRACTICE.

SIR: History is repeating itself. And as in the past two millennia in medicine it had a biblical colour. A government, like the ruling authority of a thousand mediæval years, proposes to burden the heart of medicine and confine its mind by placing it in the control of five hundred administrators. And in medicine already, there are Jeremiahs and a Judas or two. The former, not many, go hither and thither, like one good, if lugubrious, soul I met last week, saying confidentially: "A salaried service is sure to come, indeed I have inside information it will; therefore, we had better save what we can from the wreck." The latter, sedulously and insidiously, as is the wont of Judases, encourage submission to an evil plan and an evil force that they may attain the sullied things, pay and position, that have been dangled before them. But there have always been Jeremiahs and Judases and neither have yet, in any age, been good leaders to follow. They either foretell tragedies that never occur or they betray a moral force,

which prevails in spite of them and in virtue of its own excellence.

There have been occasions in history when a good people has appeared on the verge of destruction. Such an occasion there was but two years ago, in the present memory of us all, when the people of Britain survived, as will surely be told in the days to come, only by the consciousness of their supreme faith and right. They believed in themselves, they had their faith, they knew it was a great thing they were part of. We in medicine, in our smaller way, believe in the greatness of the organism of which we are a part, we have faith, which is the faith of Hippocrates, 2,000 years old, in our moral purpose, and we believe that our mind and our minds are as essentially nourished on freedom as is the soul of Britain. We have but to remain conscious of the morality and the dignity and the humanity of our purpose and medicine in this country which, let it never be forgotten, is a part of medicine of the whole world and of medicine of 2,000 years, moving on from age to age as one magnificently purposeful whole, will never pass into the intellectual thraldom of governmental administration.

It has been said that the draft scheme of the National Health and Medical Research Council for a salaried medical service—general practitioner and consultant—is the most important document ever received in silence by the profession in Australia, and that it should have been discussed by doctors for the reason, among others, that it will certainly be used by the Government as the basis for discussion with the profession of the future status of medicine. That draft scheme should have been received in silence—or with loud condemnation; for it is as bad a scheme for an efficient medical service as there could be. It was drawn up by a body of fifteen, of whom but two were practising doctors. Of those two, one voted against its acceptance; the other accepted it provisionally as it retained the right of private practice. And, as should therefore be expected, throughout the draft there is displayed an ignorance of the essential features of medical practice.

Indeed this draft is not the outcome of an attempt to consider the whole question of what should constitute an efficient medical service to the people. And no one would deny that that is the primary need. Right at the outset of the draft the real question in the minds of the majority of the Council became crystallized and this was not so much the construction of a more efficient medical service; it was frankly the nationalization of medical practice. The Council, without reporting how the present organization might with advantage be built on so as to retain its main principles and yet acquire added efficiency in function, made the *a priori* assumption, much after the manner of the judicial official who composes his verdict before hearing the evidence, that it must go, that in effect and in the course of time it was to be displaced by salaried personnel giving the services, while hundreds of administrators would supervise them from offices at enhanced and relatively higher rates of salary. *Vide* this salient sentence in the preamble of the draft: "The Council, therefore, has prepared this outline (which it does suggest is a final and complete scheme) as a basis for the discussion of a reconstructed relationship between the Government, the people and the medical profession." That is but an euphemious declaration that the Council's original purpose was to nationalize medicine.

To do this, the Council is prepared to effect two things repugnant to justice and efficiency. It would create another vast bureaucracy, and it would without any mention of compensation deprive existing practitioners of the capital value of their practices, which in most cases represents the greater part or the whole of their life's savings.

The Council would, however, wreak a more profound and lasting destruction than those. The scheme would destroy the basis of the patient's confidence in the doctor by destroying freedom of choice; it would subvert the doctor's efficiency, because he would have to decide not only the right course in the patient's interest, but how far it met with the approval of his seniors in the service, for on their report would depend his prospect of advancement. Intellectual shackles and the system of favouritism would replace free exercise of a trained mind and the patient's satisfaction as the criteria of the doctor's progress. The Council, then, says the family doctor must go, and so further it indicates its want of familiarity with the people's needs. The patient does not come to the doctor as a unit, a cypher, a mere piece of organic matter, to be card-indexed and catalogued, but as a living human being with aspirations and daily problems, and his family doctor is the one person to whom he ever could disclose his most intimate concerns. It is frequently out of these disclosures that the right course of treatment for his restoration is discovered. Hence, indeed, modern psychiatry and psycho-somatic medicine. It would be well if we all read Sir Beckwith Whitehouse's dignified and magnificently effective justification of the family doctor in the *British Medical Journal* of September 26 last and compare it with the substance of the Council's draft scheme.

I have already set out in this journal and before the Parliamentary Joint Committee on Social Security what I believe to be the necessary constructive measures to raise the efficiency of medical practice and its service to the people. After a long session with that committee and considering the many factors involved, I have less faith than ever in the Jeremiahs. The medicine which we value as a precious thing, evolving slowly but soundly through 2,000 years, will not go. But it can and will be made a greater and a sounder and a more efficient structure by now necessary additions.

Yours, etc.,

Earlwood, Sydney, January 4, 1943. H. R. R. GRIEVE.

SIR: I had considerable difficulty in following Dr. Boyd Graham's train of thought in one part of his address to the Victorian Branch. Expressing his general disapproval of a salaried service, he states: "I for one should hate for a wage to sell health across the counter to my clients." This remarkable statement is surely more applicable to our present system than to a salaried system. The brutal truth is that "fee for service" practice is medical merchandising, selling our talents to those who can pay. It binds our material welfare irrevocably to the ill health of the community. Consider how we thrive on an epidemic. Note well the fact that two cremation certificates per day would pay our income tax. I hope and trust that more and more of us will protest against this unfortunate form of reward which capitalizes human distress.

Yours, etc.,

Enmore, Sydney, January 4, 1943. L. HEWITT.

Naval, Military and Air Force.

APPOINTMENTS.

THE following appointments have been promulgated in the *Commonwealth of Australia Gazette*, Number 337, of December 31, 1942.

ROYAL AUSTRALIAN AIR FORCE.

Citizen Air Force: Medical Branch.

Temporary Squadron Leader W. McL. Borland (1477) is granted the acting rank of Wing Commander whilst employed as a Wing Commander with effect from 23rd January, 1942.

The following Flight Lieutenants are granted the acting rank of Squadron Leader whilst employed as Squadron Leaders with effect from the dates indicated: D. C. Howie (1264), B. J. Basil-Jones (1289), 4th March, 1942; C. A. Frew (1604), 1st July, 1942; C. G. Davidson (1283), 16th July, 1942.

Australian Medical Board Proceedings.

QUEENSLAND.

THE undermentioned have been registered, pursuant to the provisions of the *Medical Acts*, 1939-1940, of Queensland, as duly qualified medical practitioners:

Barr, Alan Alison, M.B., B.S., 1942 (Univ. Queensland), "Albany", Herston Road, Herston.

Buchanan, Angus John, M.B., B.S., 1942 (Univ. Queensland), Station Road, Oxley.

Gaven, Thomas Herbert, M.B., B.S., 1942 (Univ. Queensland), "Oakwood", c.o. Post Office, Surfers' Paradise.

Harvey, Bagenal Crosbie, M.B., B.S., 1942 (Univ. Queensland), Post Office Residence, Ipswich.

Henry, Victor Brice, M.B., B.S., 1942 (Univ. Queensland), c.o. Mrs. Brice Henry, Tully.

Marks, James Keith Livingstone, M.B., B.S., 1942 (Univ. Queensland), "Bungalora", via Tweed Heads.

Pike, Kenneth Henry, M.B., B.S., 1942 (Univ. Queensland), Winchester Street, Southport.
Wilson, Esther Frances Gilmore, M.B., B.S., 1942 (Univ. Queensland), Brisbane Street, Ipswich.
Tod, Peter Alexander, M.B., B.S., 1942 (Univ. Sydney), General Hospital, Brisbane.
Tonakie, Anthony John, M.B., B.S., 1942 (Univ. Queensland), 92, Vulture Street, West End.
Ferrari, Louis Norman, M.B., B.S., 1942 (Univ. Sydney), Mater Hospital, Brisbane.

The undermentioned has been registered, pursuant to the provisions of the *Medical Acts*, 1939-1940, of Queensland, as specialist in Radiology and Radiotherapy.

Michel, Max, Rothwell's Chambers, Edward Street, Brisbane.

Obituary.

ALFRED MILLAR FORD.

WE regret to announce the death of Dr. Alfred Millar Ford, which occurred on January 2, 1943, at East Malvern, Victoria.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

Adderton, Dorothy Isabel Orion, M.B., B.S., 1941 (Univ. Sydney), 4, Pritchard Street, Auburn.
Parker-Smith, Winston, M.B., 1942 (Univ. Sydney), 31, Wycombe Road, Neutral Bay.

The undermentioned have been elected as members of the New South Wales Branch of the British Medical Association:

Bishop, Peter Orlebar, M.B., B.S., 1940 (Univ. Sydney), Flat, No. 2, 53, The Esplanade, Balmoral Beach.
Brodie, Gordon Marcus, M.B., B.S., 1940 (Univ. Sydney), 32, Cheltenham Road, Cheltenham.
Dey, Robert Middleton, M.B., B.S., 1942 (Univ. Sydney), 310, Miller Street, North Sydney.
Powys, Norman Skelton, M.B., B.S., 1942 (Univ. Sydney), 2, New South Head Road, Vaucluse.
Shellshear, Joseph Lexden, M.B., 1907, M.D., 1929 (Univ. Sydney), 20, Harriette Street, Neutral Bay.
Watson, Shane Andrew Clarke, M.B., B.S., 1939 (Univ. Sydney), 34, Beaconsfield Road, Balmoral.

Medical Appointments.

Dr. Ronald Cuttle and Dr. Rupert Gordon Weaver have been appointed members of the Advisory Committee on Technical Courses at Junee, New South Wales.

Books Received.

"Recent Advances in Obstetrics and Gynæcology", by A. W. Bourne, M.A., M.B., B.Ch. (Cambridge), F.R.C.S. (England), F.R.C.O.G., and L. H. Williams, M.D., M.S. (London), F.R.C.S. (England), F.R.C.O.G.; Fifth Edition; 1942. London: J. and A. Churchill Limited. 8" × 5¼", pp. 372, with illustrations. Price: 18s.

"Illustrations of Surgical Treatment, Instruments and Appliances", by E. L. Farquharson, M.D., F.R.C.S.E., with a foreword by Sir John Fraser, M.C., M.D., Ch.M., F.R.C.S.E.; Second Edition; 1942. Edinburgh: E. and S. Livingstone. 9¼" × 6", pp. 404, with many illustrations. Price: 25s. net.

"Report of the Committee on Tuberculosis in War-Time", Medical Research Council of the Privy Council, Special Report Series Number 246; 1942. London: His Majesty's Stationery Office. 10" × 6", pp. 36. Price: 9d. net.

"Recent Advances in Anæsthesia and Analgesia (Including Oxygen Therapy)", by C. Langton Hewer, M.B., B.S., D.A. (R.C.P. and S., Eng.); Fourth Edition; 1943. London: J. and A. Churchill, Limited. 8" × 5¼", pp. 352, with 135 illustrations. Price: 18s.

"Pain", by Thomas Lewis, M.D., F.R.S.; 1942. New York: The Macmillan Company. 9¼" × 6¼", pp. 208, with illustrations. Price: 12s. 6d. net.

"Pye's Surgical Handicraft: A Manual of Surgical Manipulations, Minor Surgery, and Other Matters Connected with the Work of Surgical Dressers, House Surgeons, and Practitioners", edited by Hamilton Bailey, F.R.C.S. (England); Thirteenth Edition; 1942. Bristol: John Wright and Sons, Limited; London: Simpkin Marshall (1941), Limited. 8½" × 5½", pp. 548, with 534 illustrations. Price: 25s. net.

"Materia Medica, Pharmacy, Pharmacology and Therapeutics", by William Hale-White, K.B.E., M.D., LL.D.; Twenty-Fifth Edition; 1942. London: J. and A. Churchill, Limited. 7¼" × 4¾", pp. 511. Price: 14s.

Diary for the Month.

JAN. 22.—Queensland Branch, B.M.A.: Council.
JAN. 28.—South Australian Branch, B.M.A.: Branch.
FEB. 2.—New South Wales Branch, B.M.A.: Organization and Science Committee.
FEB. 3.—Western Australian Branch, B.M.A.: Council.
FEB. 4.—South Australian Branch, B.M.A.: Council.
FEB. 5.—Queensland Branch, B.M.A.: Branch.
FEB. 9.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
FEB. 12.—Queensland Branch, B.M.A.: Council.
FEB. 13.—Tasmanian Branch, B.M.A.: Annual Meeting.
FEB. 16.—New South Wales Branch, B.M.A.: Ethics Committee.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phœnix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia.

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